Abstract

Governor Christine Gregoire of the State of Washington is leading *Partnerships for Recovery* with the full support and participation of the Director of every Department and Division serving people with mental illness in the State of Washington. With consumers and family members as equal partners, Partnerships for Recovery has launched a deep transformation effort to achieve the goals of the President's New Freedom Commission for all people in the State of Washington.

All aspects of the transformation will rely on the participation of consumers and families, including their membership in Transformation Work Group, in outreach, education and training, policy formation, evaluation and public education campaigns. This will insure that the transformation process will give birth to a comprehensive, culturally competent, fully integrated, consumer and family centered system committed to continuous improvement.

The template for Partnerships for Recovery is the President's New Freedom Commission Report. However what will emerge in Washington State will be unique to the needs of the consumers and families of Washington. Partnerships for Recovery is building the infrastructure to an on-going process of planning, action, learning and innovation that will result in measurable improvements in the lives of both young and old throughout the State. Key elements of the initiative will include:

1. A social marketing initiative to reduce the stigma of mental illness, increase awareness of mental health as an essential part of health, and promote support for mentally ill individuals in the community and workplace.
2. Strengthening of the statewide infrastructure for consumer and family support and advocacy
3. Development of a comprehensive approach to insure participation of consumers as service providers.
4. Reduction of ethnic and geographic disparities and enhancement of the cultural competence of all systems.
5. Adoption of a strengths-based, consumer-driven care planning model in all state departments serving mentally ill individuals.
6. Implementing training and fiscal and regulatory incentives for the expanded use of evidence-based recovery focused practices.
7. Development of a web-based data infrastructure that will support direct service, planning, and evaluation and form a basis for systemwide accountability to citizens and consumers.
8. Development of a consumer-driven formative, process, and outcome evaluation.

As chair of the TWG, Cheri Dolezal, RN, MBA, will provide the highest level of oversight to the Initiative and serve as its main link to the Governor on a full time basis. Ms. Dolezal laid the foundation for Transformation of the Mental Health System in Washington during this past legislative session when she was the engine behind the passage of 2SHB 1290, mandating consumer-involvement and a recovery orientation in mental health services.

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Section A: Statement of Need

Vision for a Transformed Mental Health System

It is our vision that all people in the State of Washington who experience mental health challenges will lead happy productive and fulfilling lives, free of stigma, in a safe and least restrictive environment. The Transformation of mental health services in Washington State, Partnerships for Recovery, will fundamentally change the way mental health care is provided and the way mental illness is perceived. State and local government will be accountable to consumers and families for cultural competence and service outcomes. The new mental health system will be consumer-driven; mental health will be understood as an essential element of overall health, and as a condition from which people can and do recover.

In our vision, mental illness emerges from the shadows of stigma and ignorance to a place of greater public understanding. This understanding transcends cultural difference because it is informed by an array of diverse cultural practices. Mental health services are transformed as consumer experiences systematically and continually guide the system. The education of consumers and their families is a necessary component of Partnerships for Recovery, where real choices, and accessible information is readily available to consumers.

In this system, the use of evidence-based practices (EBP) for early detection and prevention is an explicit priority of all service agencies. Individual/family recovery plans are coordinated utilizing a shared data system that provides ongoing information on quality of life outcomes. This data system supports continual improvement (Senge, et al. 1999) (Lewin, 1951) of all service providers and helps prevent any consumer from falling through the cracks. Care services are coordinated, goals and methods are consistent, and intake and assessment are streamlined among multiple agencies. In this new system, a consumer may enter through any door and receive high-quality, integrated services responsive to the specific and multiple needs that the consumer and his or her family present. Most importantly, consumers are practically and realistically supported to live, work, learn, and participate fully in our community. (Copeland, M.E. 1995)

This vision for Partnerships for Recovery is built around several key commitments held by the Governor, the heads of participating agencies, and by consumers, family members and advocates who have helped create this proposal.

- Mental Health services must be based on the principles of wellness and recovery, and place consumers and families at the center of all State efforts of system change and improvements.
- Consumers, families, state leaders, administrators and service providers will receive education regarding mental health and the models of client driven services that are developing throughout the nation and the world.
- Consumers and family members will be employed widely as participants in governance, administration, service delivery, and evaluation.
- The stigma of mental illness will be reduced and recovery will be possible for all consumers.
- Evidence-based practices will be implemented, and the wellness/recovery model will be integrated into culturally competent individualized treatment plans.
- All policies, and programs will ensure that continuity, alignment, and quality of care occur.
- Transitions from one age cohort to another (e.g., adolescents becoming adults, adults becoming seniors) and from one life condition to another (e.g., prisoners being paroled, homeless people becoming housed, etc.) will be facilitated in a person-centered fashion;
- The principle of least restrictive means will be practiced, including diversion of individuals with SMI diagnoses from prisons and jails; and
- Coordination and collaboration among agencies that provide services to mental health consumers will become more effective and systematized, and those services will become increasingly aligned in philosophy and approach.

Six Goals to Transform the Infrastructure of Mental Health Service and Delivery

The Partnerships for Recovery Transformation Working Group (TWG) is developing a shared understanding and a common agenda for transforming Washington's mental health system that is focused on the six New Freedom Commission goals. Principal activities of Partnerships for Recovery

under each of these goals are outlined below. (DHHS 2003)

President's Goal 1: Americans understand that Mental Health is Essential to Overall Health

Over the grant period, the State of Washington will implement a targeted series of public education campaigns focused on promoting public awareness, reducing stigma, and promoting wellness and early entry into care.

Community and Family Social Marketing Initiative:

This Initiative will:

1. Reduce the stigma of mental illness and implement the national suicide prevention strategy;
2. Foster awareness that mental health and physical health are equally important and that each is necessary in order to achieve wellness.
3. Promote concepts of recovery, self-respect and dignity of those suffering from mental illness;
4. Inform people about what they can do to promote mental health in themselves, their families and communities
5. Promote understanding of the early signs and symptoms of mental illness
6. Encourage individuals to seek treatment and provide them with information on how to find affordable services in their communities;

Business and Employer Social Marketing Initiative

7. Launch a workplace campaign (including State government) to inform employers about the business costs of mental illness, encourage employers to inform their employees of care options and ensure that health plans cover mental health services;
8. Ensure that within the workplace individuals with mental health issues are not stigmatized but are supported in their efforts to seek treatment;

Each campaign will be coordinated in message and approach with Federal social marketing efforts. Each will focus on promoting action among the target audiences with a particular effort made to produce culturally specific and linguistically accessible content for each of Washington's principal ethnic communities. Each initiative will be carefully designed and fully tested with focus groups and market surveys. Recognizing that the consumer "marketplace" is in constant flux, the Initiative will continually monitor and adjust its messages to ensure continuing efficacy.

President's Goal 2: Mental Health Care Is Consumer and Family Driven

Partnerships for Recovery will implement a multifaceted approach to ensure that mental health services are consumer and family driven and to change the way that services are delivered, resulting in a deep structural transformation and transparency (Brin, D. 1998) of the many systems that serve individuals with mental health issues. Elements of this approach include:

a. Development and strengthening of a statewide consumer and family infrastructure:

1. Building upon the current state, regional and local consumer organizations develop a statewide consumer organization that will work with and attain equal stature with the statewide family organization within the State of Washington.
2. Partnerships for Recovery will ensure that consumers and family members receive the support, training and financial resources they need to participate as full partners in the planning, policy making, strategy development and implementation of the State Transformation.

b. Models, Guidelines, Standards, Training and Implementation of strength-based consumer driven care individualized care planning methodologies such as WRAP and other emerging culturally competent evidence based practices will be developed and deployed.

3. The successful service planning achieved by Washington State's Individualized and Tailored Care for children will be extended to adults, offering all consumers strength based, family focused individualized plans of care. We will provide training and technical assistance to Regional Support Networks (RSNs) to utilize Individualized Recovery Plans for children and adults.

c. Implementation of a workforce development strategy to promote utilization of peer-professionals in direct service, management, and supervisory roles

4. Community colleges and other training institutions will be encouraged to offer certification programs to transition more consumers to peer professionals to meet the needs of identified mental health occupational shortages.
5. Partnerships for Recovery will establish the mechanisms whereby meaningful inclusion of mental

health consumers and family members' viewpoint and experiences are incorporated in the training and education programs for professionals and peer professionals.
6. Partnerships for Recovery will build upon nationally recognized curriculum standards and programs for training of peer professionals and expand stipend programs for consumers and family members enrolled in community and state colleges and universities.
7. Partnerships for Recovery will work with RSNs, Clubhouses and other family, consumer and advocacy groups to ensure consumer and family involvement at the local level.

d. Mandate involvement of consumers and family members in policy, evaluation, and quality assurance mechanisms on the state and local levels

8. Partnerships for Recovery will create a Comprehensive Mental Health Plan (CMHP) that will expand consumer and family involvement.
9. Partnerships for Recovery will align relevant State programs (mental health block grants, substance abuse, etc.) to improve access and accountability for mental health services.

President's Goal 3: Disparities in Mental Health Services are eliminated

a. Reducing Ethnic Disparities

1. Partnerships for Recovery will develop a State cultural competency plan that is consistent with the national standards for cultural and linguistically appropriate services in health care.
2. Partnerships for Recovery will develop state guidelines and requirements for all RSNs regarding cultural competency and mandate that all RSNs submit plans for approval to the State
3. Partnerships for Recovery will implement a system to measure the extent to which implementation of these plans at the State and local has reduced disparities.
4. Because data indicate that certain populations are underserved, Partnerships for Recovery will provide incentives to RSNs to conduct outreach and services delivery to those populations, including but not limited to women, Asian Americans, African Americans, Latinos, and Native Americans, particularly in rural settings.
5. Partnerships for Recovery will work with local service providers, RSNs and the Centers for Medicare and Medicaid Services (CMS) to make regulatory changes that facilitate the use of traditional cultural healing practices as funded services.
6. Workforce development activities will promote recruitment and education of people of color into the mental health professions. (This activity will also be supported and supplemented by the workforce development activities listed under Goal 5.)
7. Partnerships for Recovery will reach out to culturally diverse communities to develop publications and information relevant to these groups.

b. Reducing Rural-Urban Disparities

8. Partnerships for Recovery will create workforce development initiatives to improve access to care in frontier regions and provide incentives for mental health practitioners who work in underserved areas.
9. Partnerships for Recovery will put into place a statewide system that utilizes telemedicine to provide diagnosis, treatment, and specialty care in underserved rural areas.
10. The Transformation Working Group (TWG) and its subcommittees will meet in rural areas.

President's Goal 4: Early Mental Health Screening, Assessment and Referral to Services are Common Practice

a. Preschool age populations

1. Partnerships for Recovery will develop and implement a training plan for early childhood workers to recognize early signs of emotional/behavioral problems and make appropriate referrals.
2. Partnerships for Recovery will expand the use of the Ages and Stages (0-5) Assessment in early childhood settings.
3. Partnerships for Recovery will target public education to parents of young children (cf. Goal 1).
4. Partnerships for Recovery will develop and implement a training plan for primary care physicians to screen and recognize early signs of emotional/behavioral problems and make appropriate referrals (also applies to all other age groups). Partnerships for Recovery will mandate behavioral health screening as a required part of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) exams and make it a reimbursable service (also applies to school-age group.)

5. Partnerships for Recovery will promote use of Individuals with Disabilities Education Act (IDEA) Parts B and E for screening and early intervention (also applies to school-age group).

b. School age populations

6. Partnerships for Recovery will implement regulatory changes to facilitate school health clinics to bill Medicaid for mental health services at fair rates.
7. Partnerships for Recovery will advance out-stationing RSN-funded mental health staff in schools;
8. Partnerships for Recovery will educate teachers, Child Protective Service (CPS) staff, and Juvenile Rehabilitation Administration (JRA) staff in identification and referral for emotional and behavioral problems.
9. Partnerships for Recovery will educate parents and family members in identification of and treatment resources for emotional and behavioral problems in their children. (cf. Goal 1)

c. Transition age populations

10. Partnerships for Recovery will educate providers and RSNs about evidence-based practices (EBP) and encourage their use regarding prevention of first break.

d. All ages

11. Partnerships for Recovery will mandate the use of a common intake screening tool to identify co-occurring mental health and substance abuse disorders upon entry into any mental health or substance abuse treatment program.
12. Partnerships for Recovery will create incentives for the expansion of co-occurring SA/mental health capacity on the local level.
13. Partnerships for Recovery will develop methods for utilizing Medicaid waivers to facilitate dual licensing, dual staff certification, unified charting, and blended funding for treatment.

President's Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated

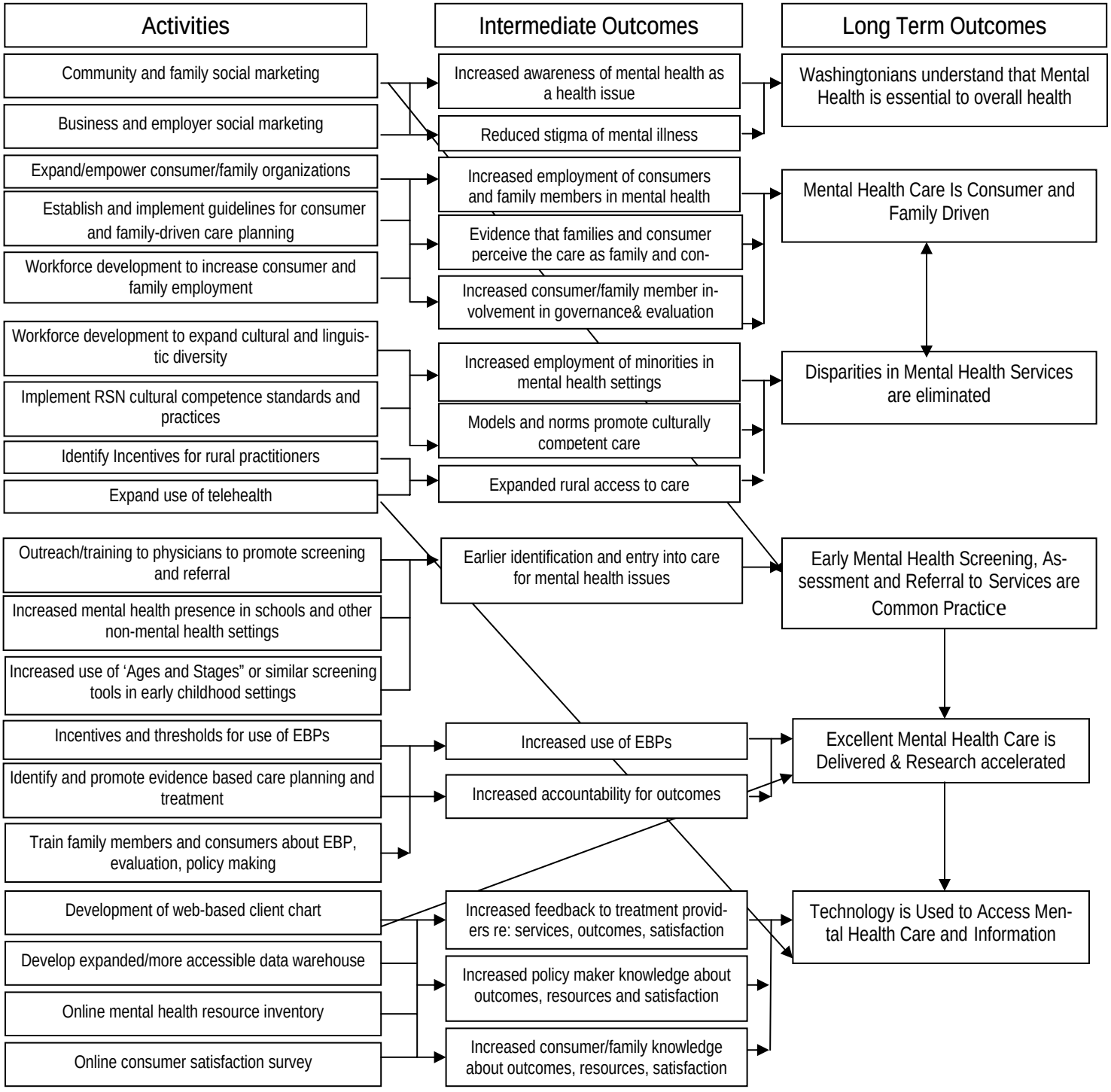
1. Partnerships for Recovery will advance the use of EBSs in RSNs through the use of incentives and training
2. Policies will be developed for individuals and their families with mental illnesses to use a variety of treatments and supports effectively within a single program.
3. Partnerships for Recovery will develop guidelines in consultation with researchers, service providers, consumers, and families that reflect what is learned about the most effective programs for children, adults and older adults and how new knowledge can be integrated into service design.

Presidents Goal 6: Technology is Used to Access Mental Health Care and Information

1. Partnerships for Recovery will increase the number of rural, and underserved areas in the State that have access to mental health services via telehealth (cf. Goal 3)
2. Partnerships for Recovery will develop a statewide-integrated web-based HIPAA-compliant electronic medical record consistent with Federal policies and initiatives.
3. Partnerships for Recovery will expand Washington's current central data warehouse known as the Client Services Data Base (CSDB), currently housed in the Department of Social and Health Service's (DSHS) Research Data Analysis (RDA), to include all agencies participating in the transformation, and develop a secure web-based report writer that would be accessible to authorized users in all participating agencies.
4. Partnerships for Recovery will modify existing statewide consumer satisfaction survey process to track transformation, and will make survey results available to consumers through the web and at Consumer Roundtable and conference settings, and will involve consumers in the analysis.
5. Partnerships for Recovery will create a web-based outcome reporting system that will be available to the general public (Brin, D. 1998) and will report on indicators of risk and need, including: Mental health prevalence rates and outcomes, Suicide Rates, School behavioral health indicators, Child Welfare outcomes, Juvenile Justice outcomes, and Success Stories of recovery.
6. Partnerships for Recovery will enhance Geographic Information System (mapping) capacity to help translate relevant outcome and other data results into information that can be communicated to service providers, consumers, and families.

While the current plan is preliminary, Partnerships for Recovery has established a blueprint for progress of the Transformation that will serve as a guideline for the TWG. The logic model below lists anticipated activities and how they correspond to both intermediate and long-term goals.

LOGIC MODEL



Documentation of Need

Needs Assessment

One component of the needs assessment was an analysis of Washington State data on estimates of mental health care need, utilization, and potential gaps in services. The primary sources of data used in this analysis included: 1) *State-Wide Publicly Funded Mental Health Performance Indicators, Fiscal Year, 2003* (WA State DSHS); 2) *The Prevalence of Serious Mental Illness in Washington State*

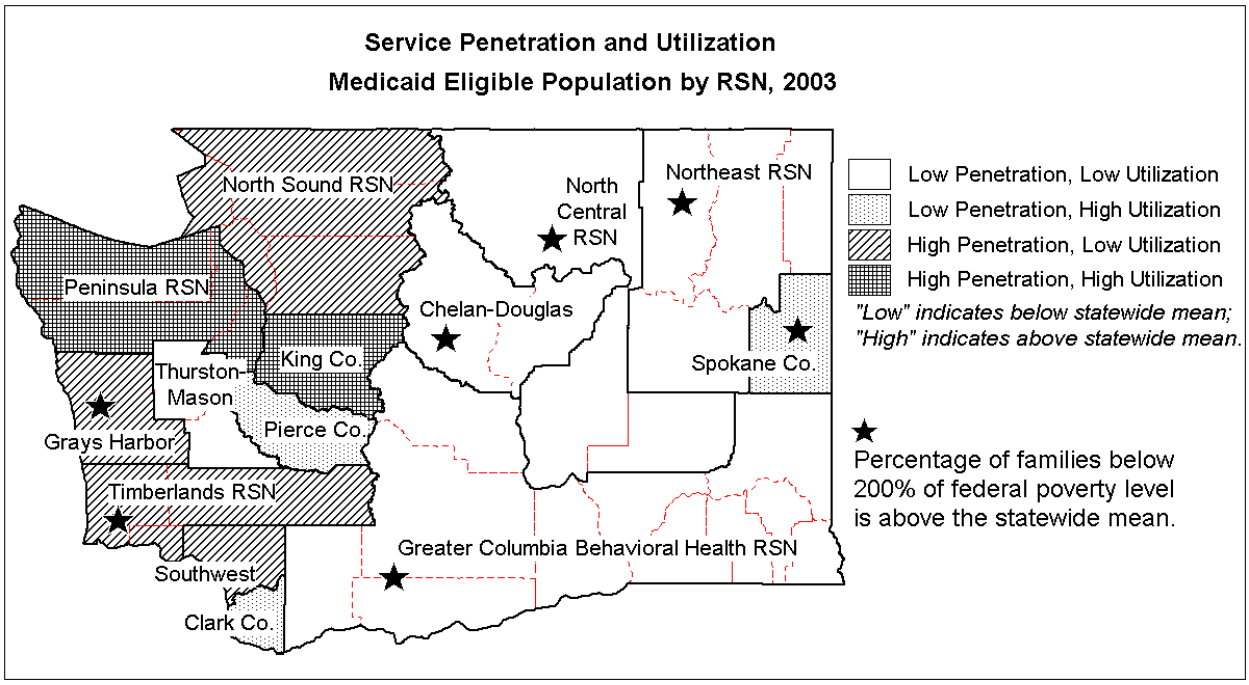
(WA State DSHS, 2003) which included findings from a household telephone survey; and 3) Client Services Data Base, a central research data warehouse maintained by Research and Data Analysis division of DSHS. Presented below is a portion of that analysis.

Differences and Gaps by Gender, Ethnicity and Age

Although 12% of adults in Washington State were estimated to have a clinical mental health condition in 2000, only 2% of state residents received public outpatient mental health treatment in 2002. Children were more likely to use treatment (2.5%) than were adults aged 18-59 (2.2%) or elderly (1.5%). People who received Medicaid were more likely to receive public outpatient treatment (8% overall), with higher percentages of use among those aged 18-59 (13.5%) than elderly (8%) or children (4.7%). Asians had the lowest percentages of adults and children in public outpatient treatment (0.7%). Hispanics also had low public outpatient treatment (1.9%). Caucasians had low general use of outpatient services (1.5%) and high adult estimated need (4.2%). The highest rates of outpatient treatment were reported among Native Americans (3.5%) and African Americans (3.9%), both of whom had relatively high reported adult need (respectively, 5.9% and 3.9%).

Gaps in Need for Treatment, Receipt of Medicaid, and Receipt of Treatment by RSN

On average, about half of mentally ill individuals were estimated to be living below 200% of poverty and eligible for Medicaid. Of the estimated 148,590 persons with a mental health condition living below 200% of poverty, 85,891 or 58% received public outpatient treatment in 2002. The map shows that even when people may be eligible for Medicaid-funded services, they do not necessarily use public mental health services. It is not clear if this is a problem of lack of eligibility specifically to receive mental health services, need for additional and targeted outreach in poorer areas, issues of stigma that interfere with people in need choosing to use services, or other issues. The interaction of these possible factors with cultural/racial issues may also be at work. The full needs assessment has identified additional regional trends that should be further explored in the development of the mental health plan. The definition of penetration used here is the proportion of people in the Medicaid population who received publicly funded outpatient mental health services in fiscal year 2002. Utilization



is the average number of outpatient service hours per consumer for a fiscal year. High penetration was defined as above the state mean of 8% and low is below that figure. High utilization was defined as above the state mean of 25.7 hours and low is below that figure.

Receipt of Services in Other Washington State Human Service Departments

Washington State residents get help in the Mental Health Division (MHD) as well as from other

state Social and Health Service divisions. Indeed, in 2002-2003, only 20% of MHD clients received services in the Mental Health Division alone, with MHD clients representing 8% to 26% of clients in other divisions (Table 1). The three divisions with the largest percentages of MHD clients were Juvenile Rehabilitation Administration, Division of Alcohol and Substance Abuse, and Division of Vocational Rehabilitation. It is important to note that these numbers reflect only those who received services not all that were in need within each department. For example, 62% of Vocational Rehabilitation clients have a known mental health or developmental disability. Seventeen percent of the correctional population is estimated to have a mental health disorder. While 24% of clients served by DASA were also MHD clients, studies have shown that the rate of SMI is nearly 30% of those with an illicit drug or alcohol dependence. (Epstein et al, 2004). The prevalence of mental illness among the homeless, a population served by a number of TWG participant departments, is estimated at 30% to 35%– although many who work with this population would contend that figure is low (Burt, 1998; WA DSHS, 2003).

Schools can be another place where children can get mental health services. Of people counted as having serious mental health problems children counted for a substantial proportion—on average, 37% (with a range of 31% to 42% across RSNs). Yet, RSNs varied greatly in the extent to which children receiving mental health services received those at a school, with on average 13% of children who received mental health services receiving them in schools in 2002, but percentages ranging from 1.9% in North Sound RSN to 27.5% in North Central RSN.

Table 1: *Numbers &percentages of Mental Health Division clients receiving services in other Washington State DSHS Divisions*

Washington State Department of Social and Health Services	Total Clients	MHD clients in each department		MHD Clients Adults	MHD Clients Children
	N	N	%	%	%
Juvenile Rehabilitation Administration	4,201	1,073	26%	16%	84%
Division of Alcohol and Substance Abuse	54,422	13,430	25%	82%	18%
Division of Vocational Rehabilitation	29,989	6,796	23%	99%	1%
Aging and Disability Services	60,743	9,914	16%	100%	0%
Division of Developmental Disabilities	35,223	4,310	12%	69%	31%
Children's Services Administration	192,288	21,480	11%	36%	64%
Economic Services Administration	754,315	68,882	9%	72%	28%
Medical Assistance Administration	1,239,052	98,089	8%	66%	34%

The needs assessment also includes findings from a well-based transformation survey and focus groups conducted at Clubhouses throughout the State. These provided a great deal of information on both central and local efforts at transformation, identification of barriers, and suggestions for what needs to be done. A brief summary of findings is presented here.

Survey and Focus Group Findings

The transformation on-line survey has yielded input from stakeholders representing consumers across age span, families, agencies, mental health providers, RSNs, advocates, and tribal members. Many respondents identified themselves as belonging to two or more of these stakeholder groups. Common Themes frequently mentioned included the need for additional funding, collaboration and communication among agencies serving consumers with mental health needs, peer to peer support and education. Most frequently cited problems of the system included limitations of reimbursement restrictions, and variability across RSNs. Some respondents shared their hope that coordination by the State would address disparities in services.

The most frequently cited effort to reduce stigma is efforts of provider education at the community level. However, there is still a great lack of both community and provider understanding and funding is needed for stigma reduction and education. Efforts at the delivery of culturally competent services and training are occurring but much more remains to be done including recognizing a larger number of cultural groups with their own languages, problems with stigma and treatment needs such as Eastern European immigrants, deaf, gay/lesbian/transgender. Serving the special service needs of older adults encountering mental illness for the first time was identified as an area requiring attention. Another reoccurring theme is the necessity of consumers to have more ownership of their treatment, ac-

knowledgement of their role from providers, a greater willingness to include family in treatment, and a focus on individual consumer strengths and abilities. It was commented that family involvement must be balanced with the wishes of the consumer. Another barrier to obtaining services, cited by consumers and providers alike, are restrictions in care to only those whose disability or dysfunction has progressed to a severe or acute stage, even though early intervention is proven to be efficient and effective. Some efforts to serve the needs of those living in rural and remote areas include telemedicine, outreach clinics, service provision at the schools, phone consultations, circuit riding psychiatrists, and providing multiple services at one location. However, it was noted these efforts are not being implemented throughout the State. The needs of those requiring a higher level of care are especially problematic in rural areas. Some of the current efforts at using technology in rural areas include electronic medical records, telemedicine, Palm Pilots for case managers to maintain clinical records in the field. The Clubhouses have been training consumers to use internet to obtain information. The cost of technologies and training were cited as barriers, along with HIPAA compliance.

Participants of the Clubhouse focus groups cited the need for additional access to counselors and case managers, medication, and the availability of drop-in counseling. They also emphasized the importance to their successful recovery of supplementary services including: transportation, housing, education, vocational services, and employment. Unfortunately, the experience of the majority of these individuals was that they were assigned to services without an explanation of what was available. Clients were required to be resourceful and depend upon word-of-mouth to locate these services or go without. If they obtain work, they face potential loss of medical/pharmaceutical coverage. Many expressed the need for additional services for those not covered by Medicaid. A disturbing observation cited by one group was that the system seemed to encourage them to remain ill in that the sicker or "crazier" one is the easier it is to obtain services. Many found they were in an impossible situation of wanting to obtain services because they did not want to become more symptomatic, yet being denied services because they were not showing enough symptoms to qualify for services. All cited the value of the Clubhouse model and its contribution to their recovery. They felt it should be expanded to additional locations and client populations such as transitional age youth.

Current Stakeholders and Inventory of Resources for TWG

The Mental Health Division is housed within the Washington State Department of Social and Health Services (DSHS). In 2003, DSHS served 1.5 million people – about one person in four in the State. Many persons screened as having mental health problems in any of these systems will be served by more than one system during a single year, to say nothing of a lifetime. Improving screening and referral processes and coordinating provided DSHS clients is, therefore, a central management concern for Partnerships for Recovery and for the TWG. The Resource Inventory presents some of the resources available through the major departments and DSHS divisions participating on the TWG. Not represented here are the resources based in experience that consumers (adult and youth), family members, and other associations which will be participating on the TWG.

TABLE 2: STAKEHOLDER DESCRIPTION AND INVENTORY OFMENTAL HEALTH CARE RESOURCES

Staff	Funding	Programs & Policies	Facilities & Equipment
Mental Health Division (MHD): administers a full continuum of mental health treatment to consumers with emergent, acute and chronic conditions.			
14 RSNs; 145 outpatient providers (some have multiple locations); 44 residential providers; 5 free standing Evaluation and Treatment Centers; 16 Community Hospital Inpatient Units; 204 Children's beds; Over 300 professionals providing involuntary crisis intervention and hundreds of crisis inter-	Total annual State budget of $603,337,742; Parent Partners(MH Fed Funds) salaries $33,600; Parents $18,000; Consumer Voices are Born $160,000 Block Grant; NAMI $40,136 Fed Block Grant	1915(b)(4) waiver allows MHD to operate prepaid inpatient health plan Under capitation payment, allows RSNs to design individualized system of care. Cost savings used for additional services; MHD contracts with RSNs 1) Medicaid or Prepaid Inpatient Health Plan MH services as managed care benefit & 2) State Mental Health Services to uninsured; Western State Hospital Nonviolence Initiative enacts	MHD-CIS contains data collected by RSNs from community mental health centers for the State; Case Manager Locator System; Rural Consortium IT Partnership; Palm pilots used to collect data in the field for PATH grants; Consumer Outcome System DSHS Research and Data Analysis division maintains central client service database with cross-departmental

Staff	Funding	Programs & Policies	Facilities & Equipment
ventionists		least restrictive environment	service data.
Division of Alcohol and Substance Abuse (DASA): Provides detoxification and treatment, prevention and screening services			
Train counselors on COD. Fund MH counselors in perinatal and youth AOD programs. Place counselors in youth group homes, Youth-Child Study Treatment Ctr.	SAMHSA Strategic Prevention Framework-SIG 5 yr $11.5 million	COD Interagency Advisory Committee Male adult co-occurring program; Conduct annual COD/DDD conference; Additional collaborations between AOD and MH providers at local level	MIS for AOD programs includes 9 items related to MH screening; Data sharing agreement with MHD for research and evaluation
Medical Assistance Administration (MAA): Purchases managed care and fee-for-service health care for low-income Medicaid and state plan low-income persons.			
	Healthy Options premium for MH $7,878,664; First Steps counseling $3,704,777; The following are MH state/fed/HSA expenses: Pharmacy $180,867,764; Physician $3,908,876; Inpt Hospital $4,111,166; Outpatient $4,778,029	First Steps provides maternity support services/Infant case management. Psychosocial component includes screening/assessment, brief counseling, crisis intervention, case management.	
Employment Security Department: Provides employment and training services, disability placement services, administers unemployment benefits			
		Workforce Investment and Wagner-Peyser Acts support ESD's commitment to provide universal access to services for people with disabilities.; Active partner on the Workforce Disability Network	Expanding on-line access to resources related to serving job seekers with disabilities.
Children's Administration (CA): Manages child welfare and protection			
9 FTE state and local staff coordinate mental health care (co-funded by MH/CA in 4 regions).	Federal $23,720,981 State $48,356,443 SAMHSA grants in King and Clark counties and Puyallup Tribe	Programs that address MH needs: Foster Care Assessment Program; Outpt services for Sexually Aggressive Youth; Medicaid Treatment Child Care (0-72 months); Behavioral Rehabilitation Services; Family Preservation Services; Family Reconciliation Phase II; Adoption Support Counseling; Foster Care Psych. Evaluation and Treatment	CAMIS data system; FCAP assessment – 336/year SAY – 250 per year; MTCC – 300 per month; BRS – 800-1,000 point in time; FPS – 1506 families/yr; IFPS – 487 families/yr; FRS, Phase II – 134/mo; Adoption Support – 394/mo; Psych eval – 800
Juvenile Rehabilitation Administration (JRA): Provides mental health screening and treatment for convicted children and youth			
22 staff devoted to provision or coordination of MH care; All institutions have staff who are assigned duties of: Designated MH Professional; Suicide Trainer; MH assessment	$3,239,859 for residential, regional, institutions, and community services	Utilizes EBP including: Integrated Treatment Model, MDTF, FFT, FIT; Diagnostic mental health screening of all youth for tmt needs and appropriate placements; Suicide assessment and intervention; Coordination with RSNs for youth transitioning from JRA institutions; Agreement with MHD for youth requiring placement at WSH or CSTC;	63% of youth meet criteria for mental health target population.; Four JRA institutions (2 designated for more complex MH youth-84 beds); COD database on Client Activity Tracking System; Piloting Voice Diagnostic Interview Schedule at intake
Aging and Disability Services (ADSA): Administers community and institutional long-term care services; HCS (Home and Community Services) coordinates care for aging and disabled who qualify for personal care services.			

Staff	Funding	Programs & Policies	Facilities & Equipment
HCS - 12 staff at regional level; 3 staff at headquarters. Provide client assessments and case management.	Funding for ECS is from MHD. For MH support and residential providers; Federal ECS: $2,266,165; State ECS: $2,266,165	Expanded Community Services, MHD transfers funds to ADSA/HCS to coordinate residential and MH supports for long-term state hospital pt. Or those at risk of hospitalization with high need. Ten programs throughout the state; Medicaid Personal Care funds services to non-ECS clients with psychiatric disorders coordinated between HCS and local RSNs	ECS has 125 ADSA funded beds; Regional HCS contract with local facilities; geriatric ECS contracts with 10 MH providers for behavioral supports; ADSA uses the CARE tool to screen individuals for services
Division of Vocational Rehabilitation (DVR): Offers rehab services to disabled adults of working age.			
200 counselors located throughout state – 12 devoted to serve individuals with mental illnesses	$50 million basic grant is a 20/80 percent state/US Dept of Education match; Expenditures of $5,047,784 for 2,898 clients with MH disability; $294,648 to support 3 MH club houses	Support for Clubhouses; Direct services provided by DVR counselors; Purchases services for individualized case plans (mental restoration services, education, training, etc.); Counselors serve consumers on itinerant bases at community MH agencies; Liaisons identified for each MH agency	Uses client registry
Department of Corrections			
158 FTE	$4.47 million	DOC has 2,050 Seriously Mentally Ill offenders – policy directive to identify and arrange for appropriate services. ; Mental Health Care Management – assess and provide MH services to all SMI offenders; Involuntary Medication Administration to SMI offenders who pose a danger to self or others; Suicide Prevention and intervention procedures	
Office of the Superintendent of Public Instruction			
Staff at state level devoted to coordination of mental health related activities		3 past and 4 current Safe Schools/Healthy Students SAMHSA grants; Districts provide IEP services for children qualifying for special ed. services in emotionally/ behaviorally disabled; Districts work with local MH providers for special education services.; WA HB 1784 (2003) supports increased coordination of MH and education systems for screening, diagnosis and treatment of children.	
Department of Veterans Affairs			
29 community service providers for PTSD; 1 MH staff at DVA; Caseworkers in 24 tribes trained at DVA in PTSD	State with contribution from King County - $900,000; Federal VA fees - $1 million; Federal support of 5 Vet Centers $200,000	Veteran's PTSD Conservation Corps (habitat restoration rehabilitative program)	Target disenfranchised populations: women, ethnic minorities, rural vets, sexual trauma, incarcerated vets; Linkages with 24 tribes and all counties; MOA with national guard for counseling services; Local armories have crisis lines; conference calling, video diagnostic

State Demographics

Washington State is divided into two geographically distinct areas by the Cascade Range. The area west of the Cascade Range, commonly known as Western Washington, occupies about one third of the state's 66,580 square miles, with nearly 80% of the state's population of 5,894,121 residing there. Most of Western Washington's urban and industrial areas are located in the Interstate 5 corridor. Other parts of Western Washington tend to be rural with economies relying on logging, fishing, and agriculture. However, Eastern Washington is predominantly rural with two urban areas, Spokane and Yakima. Wheat, the state's leading crop, is grown primarily in Eastern Washington. Washington also produces fruits such as apples, cherries, and plums primarily in Eastern Washington, depending on a migrant work force. Washington has historically had a high unemployment rate which continues to be exacerbated by the decline in the logging and fishing industries and increased competition from foreign agricultural markets. In 2000, 10.6% of Washington's population had incomes below the federal poverty level.

Washington has 29 federally recognized Native American Tribes with Native Americans comprising 1.6% of the population. Washington's population is 82% white, 6% Asian/PI, 3.2% African-

American, and 7.5% Hispanic. Washington's actual Hispanic population is larger than reflected in census due to the migrant work available in the agricultural market. Washington continues to attract immigrants as situations in parts of the world change as demonstrated by the influx of immigrants from East and West Africa and the former Soviet Union.

Prevalence of Mental Illness

Estimates based on a household survey of Washington State respondents suggest that almost 12% of state residents had a clinical mental health disorder in 2000 (DSHS, 2003). For those living below 200% poverty that rate rose to 15%. Estimated rates of depression (8.60) were higher than those for panic attacks (4.75), anxiety disorder (2.75), psychosis (.68), and manic episode (.46).

Four percent of respondents had a medium-definition health need (defined as having a major clinical disorder and one of the following—a functional limitation, use of or desire for mental health services, being a danger to self or others, or being dependent on public assistance or unable to support oneself). Table 3 below compare rates of medium-definition health need by demographic and regional factors. However, it should be noted that this is based on self-report data and thus rates will undoubtedly reflect comfort in sharing this information. Data on medium level health need was not available for children from this survey. However, based upon a prevalence rate of 7% cited in the scientific literature there are an estimated 105,969 children age 0-17 with SED in Washington.

Women's general rate of medium-level mental health need was twice men's with even higher rates for poor women. Among ethnic groups, general rates of medium-level mental health need were highest for Native Americans, followed by Whites and African-Americans. People aged 25-44 had higher rates of medium-level mental health needs than did other age groups. Poverty was associated with higher levels of mental health needs for Whites and those aged 45-64.

Table 3: Estimated rates of medium-level mental health need by gender, ethnicity, age, poverty, and RSN

	Total		Below 200% poverty	
Demographic item	N	Rate	N	Rate
Male	54,829	2.54	12,670	2.94
Female	114,878	5.17	46,433	8.27
Ethnicity				
Asian	3,858	1.45	1,771	2.27
Hispanic	6,620	2.51	3,929	3.23
African American	5,109	3.87	2,599	5.95
Caucasian	150,607	4.12	48,972	6.75
Native American	3,513	5.93	1,831	8.03
Age				
18-24	14,463	2.59	8,937	4.25
25-44	95,646	5.27	33,727	8.05
45-64	44,873	3.34	15,411	7.55
65+	14,724	2.22	1,028	.65
Poverty				
Above 200% of poverty	106,578	3.20		
Below 200% of poverty	65,224	5.89		

Section B: Organizational Structure

Chief Executive Commitment to Transformation

Before her election to the office of Governor in November 2004, Christine Gregoire served as State Attorney General, where she demonstrated a commitment to mental health issues. She led an anti-trust lawsuit against pharmaceutical companies and distributed the award primarily among mental and behavioral health service providers. She spearheaded juvenile rehabilitation reforms, and she ran for Governor on a platform of mental health parity with physical health. In March 2005, Governor Christine Gregoire signed into law Substitute House Bill 1154 (SHB 1154), dubbed the "Mental Health Parity Bill." This law provides that mental health expenses be treated with the same primacy as those incurred for physical health, and that insurance coverage mandates for medical health be ex-

tended to mental health. Upon signing the bill, she is quoted as saying, "An attitude lingers in society that mental health is somehow less worthy of our help. The burden of mental illness is compounded by the financial strains it can bring to families."

Consistent with her demonstrated concern for mental health as a statewide issue, in April 2005, Governor Gregoire initiated an effort change the way the state envisions and administers mental health services. She sent a letter to the heads of Washington State departments and an agency, asking for their cooperation in beginning a meaningful dialogue around what is and is not working vis-à-vis mental health in the state of Washington. The letter also informed these heads that, with their participation and with increased consumer voice, a Transformation in the system would be forthcoming.

As a follow-up to the letter and at the Governor's invitation, hundreds attended the Partnerships for Recovery kick-off symposium on April 13, where experts on mental health systems transformation made presentations and answered audience questions. In attendance were state officials, mental health consumers, family members of consumers, consumer-advocates, academic community members, primary and mental health care service providers, and tribal representatives. At the assembly, covered topics included:

- How to amplify and utilize the voices of consumers, families and youth, so that mental health services are responsive to and focused on their experiences;
- How to empower consumers, family and youth as decision-makers so that they may help direct the changes that need to take place;
- How to increase coordination among all of the agencies serving mental health consumers;
- How to leverage funding to make true, substantive, structural and sustainable change.

A question and answer session ensued, where dramatic change was suggested and aired by consumer, family and advocacy groups. These suggestions provide the bricks and mortar for Partnerships for Recovery, which comes directly from the Governor's office. The Governor herself signs and endorses this proposed transformation. She has personally selected and invited the members of the Transformation Work Group (TWG) to join consumers in turning this vision into a better, transformed mental health system, and she accepts ultimate responsibility for the execution of the Comprehensive Mental Health Plan that will emerge from this process.

Dynamic Leader as Chairperson of TWG

Cheri Dolezal, RN, MBA, is the Chair of the TWG and the leader of Partnerships for Recovery. With over 30 years of professional experience in the field of mental health and substance abuse, Ms. Dolezal comes to the Transformation with both practical experience and passionate vision. She holds a Bachelor of Science in Nursing from Bradley University (Peoria, IL) and is a Registered Nurse in Illinois, Oregon and Washington. She earned her Masters in Business Administration from University of Southern California. She serves currently as the Deputy Director for Social and Behavioral Health Services at the Clark County Department of Community Services and Corrections in Vancouver, Washington. For the past four years she has overseen all programs and policy related to mental health, substance abuse, developmental disabilities, and youth programs. Because of her outstanding leadership in transforming Clark County's Mental Health system, Ms Dolezal was placed on loan to the State of Washington as Project Manager and Liaison to the Washington State Joint Executive & Legislative Task Force on Mental Health & Financing for the Department of Social and Health Services. Prior to coming to her work in Clark County, Ms. Dolezal was the Regional Director for PeaceHealth Medical Center where she was responsible for an integrated mental health/substance abuse program providing support to a 20-bed psychiatric unit, as well as a 24-bed substance abuse and inpatient detox unit. She also provided oversight to outpatient programs in mental health and substance abuse in multiple counties. While in that role in Vancouver, Washington, Ms. Dolezal developed a Quality Management Plan/Workplan for the Systems of Care, as well as first public report card for the system. In addition, she provided training to contracted providers and other operations on quality management. She successfully negotiated contracts with providers and expanded the provider network and programs, further enhancing services of the County.

She was chosen by the Governor to hold the key position in Partnerships for Recovery because of her vision for consumer-centered mental health care, her ardor for the recovery model, and her proven record as an agent for change. Leading an effort as far-reaching as Partnerships for Recovery requires a balance of commanding leadership and measured sensitivity. In her many years of work

with consumers, families, multiple governmental agencies and community-based organizations, Ms. Dolezal has honed a keenly diplomatic, inclusive approach to consensus-building, exemplified by her effective ushering-in of consumer-centered change in Clark County, and by her strategic orchestration of sweeping reforms in the development of children's system of care (CSOC) in Washington. During this past legislative session she was the engine behind the passage of 2SHB 1290, legislation ensuring consumer-involvement and a recovery-based orientation to mental health treatment, building support and pushing the initiative forward, as she smoothed contentious parties and rallied consumer-advocates. This law, along with E2SSB 5763, is the launching pad for engaging in the Transformation of the Mental Health System in Washington. Her leadership style is deceptively gentle, but she is herself completely without guile. A formidable public speaker, Cheri Dolezal cuts to the heart of every issue, charming those around her with her charismatic candor. She is known to TWG members, from tribal, family and consumer representatives to law enforcement, health and governmental officials, and commands respect from all as the natural choice to lead the Transformation.

TWG Cabinet Members and Other Senior Executive Leaders

Governor Christine Gregoire, Chief Executive, has invited senior executive leaders from several state offices to join the two youth consumer representatives, two adult consumer representatives, two consumer family member representatives and the Mental Health Policy Advisory Council Chair, already identified as Partnerships for Recovery TWG cabinet members. Each of these offices and departments was selected because of its integral role in the lives of mental health consumers, and because of its valuable experience in mental, behavioral and emotional health projects.

Office of the Governor
Department of Social and Health Services, Health and Rehabilitative Services Administration (HRSA) Mental Health Division (MHD) Division of Vocational Rehabilitation (DVR) Division of Alcohol and Substance Abuse (DASA) Medical Assistance Administration (MAA) Children's Administration (CA) Juvenile Rehabilitation Administration (JRA) Aging and Disability Services Administration (ADSA)
Department of Corrections
Washington Association of Sheriffs and Police Chiefs
Department of Health
Department of Public Instruction
Employment Security Department
Department of Veteran's Affairs

Office of the Governor

As the ultimate lead in Partnerships for Recovery, the Governor has appointed one of her top advisors to sit on the TWG. The Governor's office was involved in the research, advocacy and eventual passage of SHB1154, E2SSB 5763, and of E2SHB 1290, all of which make mental health a clear priority for the state and allow for a greater allocation of resources for services that provide for mental health recovery. E2SHB 1290 and E2SSB 5763 specifically call for greater consumer involvement and increased reliance on a recovery-based model. These legislative accomplishments drive the momentum by which the Transformation is taking place. With an emphasis on uniform statewide data collection and on using EBPs, this legislation represents an early and important step in the transformation process, and demonstrates that the Governor and the Legislature are ready to implement far-reaching reforms in the state's approach to mental health services.

Department of Social and Health Services

The TWG involves several Departments and Administrations, but none is better represented than the Department of Social and Health Services (DSHS), with top officials coming to the TWG from five separate Administrations and three Divisions within DSHS. DSHS is the largest state agency in Washington, with 18,000 employees and an annual budget of $8 billion. It oversees the provision of

health services for the poor, services for the developmentally disabled, mental health care, welfare programs, foster care, juvenile offender treatment, child welfare, services for the aging, vocational rehabilitation, and alcohol and substance abuse recovery. All of the collaborative efforts at coordinated services described below involve DSHS, and many are housed entirely within DSHS.

Health and Rehabilitative Services Administration (HRSA)

Under the umbrella of DSHS is the Health and Rehabilitative Services Administration (HRSA). HRSA has overseen several important and innovative programs to coordinate and improve how recovery services are implemented, the most significant of which is the Children's Mental Health Initiative (CMHI). CMHI represents an unprecedented alliance among three key Administrations within DSHS: Juvenile Rehabilitation Administration (JRA), the Children's Administration (CA), and Health & Rehabilitative Services (HRSA). The initiative's strategies are to introduce and expand EBP use with children and families, to develop a shared program of high-intensity services for children and youth with the most complex needs, to create jointly financed care management for high-intensity services, and to collaborate with families and stakeholders to develop an ongoing communication plan. In this initiative, the three Administrations integrate as many administrative functions as possible, such as: common training, monitoring and adherence for each EBP, common criteria for access, common gate-keeping mechanisms for the hardest to serve, and sharing of data and resources. This successful pilot is critical to the Transformation process, as it contains lessons about collaboration and consumer/family involvement, and stands as a model for how discrete agencies meld resources, standardize procedures, and build upon each other's strengths.

Mental Health Division (MHD)

As a leader in a number of collaborative efforts aimed at transforming the mental health system the Mental Health Division is situated under HRSA in DSHS and has oversight of the adult State Hospitals as well as the Children's Hospital. MHD is a partner in both CMHI and MMIP (described below), the two most prominent and innovative integrated services projects in the state. MHD is also involved in developing the State Prevention Framework through a CSAT SPF-SIG grant. Key partners from Community Mobilization, Division of Alcohol and Substance Abuse, Department of Health, Department of Mental Health, Family Policy Council, the Governor's Council on Substance Abuse and the Office of Superintendent of Public Instruction, collaborated in the development of a State Epidemiological Workgroup, an SPF Advisory Council and a Joint Operations Team, to work together to support the strategies proposed in Washington State's Strategic Prevention Framework (SPF) State Incentive Grant (SIG). The SPF SIG provides the resources necessary to enhance existing assessment processes, implementing and evaluating evidence-based strategies based on epidemiological data, and establishing reporting procedures tracking progress toward preventing ATOD use and abuse. Additionally MHD is a collaborating agency in The Pathways Program at the James Oldham Treatment Center in Yakima. This program provides integrated chemical dependency/mental health treatment for adult males in a residential setting. With braided funded from the Division of Alcohol and Substance Abuse, Mental Health Division, and Greater Columbia Behavioral Health, the 16-bed program targets chemically dependent patients who also suffer from thought disorders, bipolar disorders, schizophrenia, and major depression and neuroses.

Division of Alcohol and Substance Abuse (DASA)

The Division of Alcohol and Substance Abuse (DASA) falls under the administration of HRSA within DSHS. DASA's experience in creating effective data systems, in engaging consumers and transitioning them into provider roles, and in collaborative prevention strategies will be highly influential in the development of a Comprehensive Mental Health Plan for the state. DASA's data systems are among the administration's most comprehensive and most efficient for tracking client outcomes, but address only substance abuse outcomes. It is widely recognized that DASA is at the forefront on management of information systems, as well as facilitating the path for consumers becoming peer resources.

DASA also collaborates with several agencies in Safe Babies, Safe Moms. DASA, the Children's Administration, Economic Services Administration, Medical Assistance, and Research and Data Analysis work with the state Department of Health and local service agencies to provide services to

substance-abusing pregnant and parenting women and children ages birth-to-three. Safe Babies, Safe Moms aims to stabilize women and their young children, identify and provide necessary interventions, and assist women in gaining self-confidence as they transition from public assistance to self-sufficiency. The project has sites in Snohomish, Whatcom, and Benton-Franklin Counties. In addition to chemical dependency treatment, women are assisted in gaining access to local resources, including family planning, safe housing, health care, mental health care, domestic violence services, parenting skills training, child welfare, child care, transportation, and legal services.

In addition to these strengths, DASA has had an important role in developing a State Prevention Framework through a CSAT SPF-SIG grant described below.

Division of Vocational Rehabilitation (DVR)

The Division of Vocational Rehabilitation (DVR) is part of HRSA. DVR serves clients with individualized service plans, addressing mental health and developmental needs along with vocational rehabilitation. This encompassing approach is indicative of the Division's orientation to client care. DVR stands out in its substantive support of consumer recovery by funding the Clubhouse movement in the state. Clubhouses are consumer-centered centers providing social, vocational, and employment opportunities to assist mental health consumers in transitioning into meaningful and self-sustaining community participation. A strong coalition of six certified Clubhouses around the state join eight other Clubhouses that are not yet certified and several drop-in centers, in giving consumers a way to take charge of their own recovery into jobs and autonomy. These efforts on the part of DVR are vital to the vision of the Transformation as Clubhouses are important features of a consumer-centered, recovery-based approach to mental health. DVR's expertise in this area will be relied upon in the development and expansion of Washington State's network of Clubhouses.

Medical Assistance Administration (MAA)

Also under DSHS, the Medical Assistance Administration (MAA). MAA is on the cutting edge of information system development and has recently put into place a data system, Patient Review and Restriction (PRR), that allows more effective electronic access to patient records and communication among service providers. The Medicare/Medicaid Integration Project (MMIP) is an innovative program that integrates several agencies and divisions in the overall care of health consumers. Like CMHI, MMIP is a pilot program that represents a high level of agency cooperation, building on the collaboration of the Aging and Disability Services Administration (ADSA), the Division of Alcohol and Substance Abuse (DASA), Mental Health Division (MHD), and the Medical Assistance Administration (MAA). The pilot is being applied in Snohomish County, where primary and mental health services are being coordinated through all of these agencies, working together to prevent those in need from being denied services based on their own lack of resources. With an important premise in place, that mental health care is an essential piece of overall health, this pilot is opening doors that consumers might find closed in a traditional approach where agencies are atomized and services are not coordinated. As such, MMIP stands as another important model for the Partnerships for Recovery. The wisdom being gained in the pilot and the impact it is having on consumer outcomes will provide crucial guidance to the burgeoning statewide Transformation effort.

Children's Administration (CA)

A key partner in CMHI, the Children's Administration falls under DSHS and is the overarching agency concerned with the well-being of Washington State's children, especially in the areas of foster families, adoption and preventing abuse. Coordinating with JRA and MHD in the CMHI is one example of how CA works collaboratively to ensure a child-centered approach that is responsive to the specific needs of families. Another is Families and Communities Together (FACT), a major DSHS integration initiative being piloted with projects in Whatcom County and Spokane County. The projects are focused on developing a comprehensive community network of supports and resources for needy families and children. The Economic Services Administration and the Children's Administration are working with other parts of DSHS to build strong multilateral partnerships with each other as well as with community partners, including nonprofit organizations, local service providers, local and Tribal governments, and faith-based organizations to serve children, families, and communities. In a recent federal review of the agency, it was found that CA consistently coordinates

and integrates services for children and families served by various agencies, primarily those that fall under DSHS. The computer data system at CA was also reviewed as excellent, and should serve as a resource for the data system updates and integration involved in Partnerships for Recovery.

Aging and Disability Services Administration (ADSA)

The Aging and Disability Services Administration (ADSA), is one of the pivotal partners in the MMIP program. Also under the umbrella of DSHS, ADSA is part of another important integration program that draws community members into the process of coordinating mental health and other services for clients with complex needs and multiple service providers, Community Teams for Adults. In this program, "A Teams" are multi-disciplinary teams that bring together DSHS staff and community partners to problem solve and formulate solutions for multi-need adults in crisis. Coordination of services across multiple DSHS administrations and community services is essential assuring that clients receive the appropriate array of services they need. Aging and Disability Services Administration, the Mental Health Division, and the Division of Alcohol and Substance Abuse are participants, along with the Department of Corrections, local law enforcement, Regional Support Networks, Area Agencies on Aging, local mental health professionals, doctors, and hospitals. In addition to dealing with specific client issues, participants discuss general eligibility for their programs, funding, and services. There are now 10 A-Teams across the state.

Juvenile Rehabilitation Administration (JRA)

JRA's prioritization of mental health is known throughout the state, and is exemplified by their involvement in the CMHI. This priority is also seen is in the Functional Family Therapy program for children in juvenile rehabilitation. This collaboration between JRA, juvenile court administrators, and the Washington State Institute for Public Policy brings to bear the combined efforts of willing family members and therapists to create functioning families that support their at-risk children. In response to research findings by the Institute for Public Policy, JRA and the juvenile courts undertook a quality improvement process to help Functional Family Therapy therapists improve their skills. JRA also collaborates with CA to facilitate smooth transitions for juvenile detainees returning to their communities. Staff develop individualized services, including mental health, to reintegrate the juvenile offenders who have completed their sentences back into their home communities and families, prevent re-offending, and avoid foster or group care placements.

Department of Corrections (DOC)

As studies increasingly show, there are many incarcerated offenders nation-wide afflicted with mental illness. It has become a clear priority for the Washington State DOC to address the mental health needs of its population. To that end, the Correctional Mental Health Collaboration was established. A joint effort between the University of Washington and DOC, the collaboration was established by the legislature (HB1765) in 1993, and has been funded by DOC since that time. The primary goals have been to use joint resources to address problems associated with increasing numbers of mentally ill in the corrections system. This effort has been guided by three objectives: improving the clinical management of mentally ill offenders (MIOs); reducing the rate of MIOs re-entering the prison system; and improving the post-release integration of MIOs into the community.

Department of Health (DOH)

In addition to its active partnership in the above listed CSAT SPF-SIG and Safe Babies Safe Moms, DOH several programs that address the mental health needs of Washington residents, as part of an orientation to overall health as inclusive of emotional and behavioral health. Kids Get Care (KGC) is a program to ensure that children, regardless of insurance status, receive early integrated preventive physical, oral, developmental and mental health services through attachment to a health care home. Strategies for a Healthy Future, a task-force report that detailed strategies for improved health, including mental health indicators, has resulted in a higher level of awareness statewide about the interrelated nature of mental and physical health. First Steps, Best Beginnings, and Parent-Child Health Programs also demonstrate that DOH understands the importance of mental health on overall health and development. DOH offers a wealth of resources for mental health services, including, licensed practitioners, free programs for Washington's residents, and experience in coordinating services and funding streams.

Department of Public Instruction (DPI)

Public schools are often the first point of entry for children and youth with emotional and behavioral needs. DPI is therefore a key player in the TWG. In addition to the frequent referrals that individual instructors, counselors, and staff make for students and families, DPI has several specific programs addressing the needs of the State's student body. The Autism Outreach Project is a statewide system coordinating staff development and parent/community training for children and youth with autism spectrum disorders. The BEACONS (Behavioral, Emotional, and Academic Curriculum for the Ongoing Needs of Students) work to better meet the educational needs of children with or at risk of developing severe behavior disorders (BD) or emotional disturbance (ED). The Family Educator/Partnership Project (FEPP) encourages families, educators, and community agencies to work together supporting children and youth who need special education services. The Special Education Technology Center (SETC) assists school districts and parents with special technology needs of children with disabilities. The Washington State Special Education Training for All (staff and parents) (WSSETA) provides free training available for parents, educators, and para-educators.

Employment Security Department (ESD)

ESD partners with the Office of the Governor, the Annie E. Casey Foundation, The Boeing Company, Paul G. Allen Foundation, United Way of King County, Seattle Chamber of Commerce, Department of Social and Health Services, King County Executive's Office, King County Sheriff's Department, City of Seattle, YMCA, Highline School District, North Highline Unincorporated Area Council, Refugee Federation Services, Puget Sound ESD, and King County Housing Authority in the White Center Boulevard Park Project: Making Connections Initiative. ESD's involvement in this program that improves traditionally violent neighborhoods and creates opportunities for children, youth and families includes developing Multi-Family Service Centers. Also involved in a partnership with MAA and DASA in WorkFirst, and with the CMS-funded DSHS Medicaid Infrastructure Grant, the Employment Security Department's experience in collaborative, interagency projects is expansive.

Department of Veterans Affairs (DVA)

The Washington State Department of Veterans Affairs (DVA) maintains a state-funded counseling program for veterans with war trauma and related life issues. Washington State enacted legislation in 1991 that supports the outpatient treatment of war trauma, and extends services to the Washington State National Guard and Military Reserve members deployed during times of war. It also contracts with 29 providers for posttraumatic stress disorder (PTSD) counseling, available to all war-era veterans and family members. The Transformation will build upon these essential service in coordination with other mental and behavioral health services, and with a recovery-oriented, consumer-centered approach. The expansion and coordination of DVA's Homeless Veteran's Reintegration Project (HVRP) is another key element of the Transformation, and DVA's presence in the TWG is vital.

In addition to these state agencies, several other associations, groups and individuals will be part of Partnerships for Recovery Transformation Work Group.

- Clark County Community Services
- Spokane County Community Services
- Federal Block Grant-Mandated Mental Health Planning and Advisory Council (MHPAC)
- Indian Policy Advisory Council (IPAC)[1]
- Joint Executive & Legislative Mental Health Task Force
- Regional Support Networks
- Washington Association of Counties
- Washington Association of Sheriffs and Police Chiefs

The involvement of these consumer, professional and regional representatives will ensure that the Transformation goes beyond all of the aforementioned statewide efforts for integrated, consumer and family-centered mental health services. For while these programs are important and pave the way for more sweeping reforms, most of them do not include all of the players that need to be at the table in

[1] This is a collaboration of Washington's 29 sovereign tribal nations and other American Indian organizations, providing policy and advocacy related to human services for AI/AN children, youth, and families. The Pullayup Tribe recently won a SAMHSA grant and, whether the IPAC selects a representative from that project or not, the Transformation effort will coordinate with this SAMHSA-funded effort already underway.

order for the reforms to be far-reaching and consumer-driven. The most glaring and problematic absence in most cases is the adult consumer, the youth, and the families of child consumers.

Mental Health Planning and Advisory Council and the Transformation Working Group

The State Mental Health Planning and Advisory Council (MHPAC) is an essential partner in the Transformation. The TWG will have MHPAC representation, but the role of the MHPAC will go far beyond TWG membership in the process of Transformation. While MHPAC will remain a separate group from the TWG, and retain its functions as spelled out in the Community Mental Health Services Block Grant legislation, its advisory capacity will be broadened to include annual review of the Comprehensive Mental Health Plan. MHPAC representatives will be invited to sit on every subcommittee that is formed in the execution of the Comprehensive Mental Health Plan. Annual evaluations will be supplemented with a thorough review of the year's TWG activities by MHPAC. The contents of the Comprehensive Mental Health Plan will be held to the scrutiny of MHPAC, to ensure that the TWG is abiding by the core principle that the Transformation be informed through, focused on, and driven by consumer need and consumer input.

Section C: Strategy

Involvement of Youth and Adult Consumers and Their Families in the Preparation, Development, Implementation, Evaluating and Sustaining of CMHP

Involving Consumers in Application Preparation

A week before April 13th, 2005, the Governor invited over 2,500 people from across the state to the Partnerships for Recovery Kickoff Meeting to introduce the consumer, family and professional communities to the MHTSIG. Presentations from consumer leaders and from state and national experts in mental health transformation, were followed by a lengthy Q&A session, where the largely adult consumer and family-member audience of over 375 asked questions and offered suggestions which have been molding the vision for Transformation.

In order to ensure ongoing and continuous input to the grant development the following workday, a written survey was made available on the State's Department of Mental Health web site to adults, youth, and family members all across the state. The survey was distributed to professionals and advocates, and faxed and mailed to organizations and individuals. There have been over 100 responses to that survey. The information provided has been woven into every page of this proposal, including the sections where needs and assets, and implementation and evaluation strategies are identified.

The Partnerships for Recovery Concept Paper, written several weeks in advance of the application, is also on the MHD website to solicit input from consumers, youth and family. The concept paper reflects ideas identified in the Kickoff forum, and details some goals and strategies to be included in the grant. Over 50 consumers and family members and 15 organizations responded to the concept paper with thoughtful comments and suggestions that have shaped this proposal and the envisioned implementation of the CMHP.

The State Mental Health Planning and Advisory Council will have a crucial role in the Transformation, advising and providing an annual review of the CMHP, so input from this group was sought early in the process. In several meetings, MHPAC members offered leadership and direction for the Transformation vision, which has informed every step thereafter.

Another valuable consumer resource has been Washington's Clubhouses. Director of the Washington State Clubhouse Coalition, Bill Waters, oversaw peer-led consumer focus groups at each of the state's certified Clubhouses with the express purpose of soliciting input on the Transformation process. The insights provided in these focus groups have informed the governor's office and TWG participants of the importance of substantive and increased consumer-involvement in the shaping of policy and in the daily operations of mental health-related activities.

Developing and Implementing the CMHP

Partnerships for Recovery's Comprehensive Mental Health Plan (CMHP) will evolve through the work of the Transformation Work Group and will continue beyond the submission of the plan for approval. We will build the infrastructure to an ongoing process of planning, action, learning and innovation. The cornerstones of this planning process will include: a commitment to outcomes, a

commitment to wellness and recovery; a commitment to inclusion; a commitment to collaboration and partnership; and a commitment to ongoing learning and innovation. We will rely on regular input from youth and adult consumers, and family members of mental health consumers and all other stakeholders. This input will be solicited using the internet and other technological means of communication, through direct contact with individuals who have offered their help, through public forums announced to the greater mental health community, and through the regular contributions of consumer and family representatives who will be sitting on the TWG.

- Joanne Freimund, Chair, Washington State Mental Health Planning and Advisory Council
- Two Youth Consumer Representatives: Monique Perry (rural Pierce County) and Javar Pulliam (King County)
- Two Adult Consumer Representatives: Melanie Green (Western Washington) and Rita Whigham (Eastern Washington)
- Two Family Member Representatives: One from Statewide Action for Family Empowerment for Washington (SAFE WA), and one from Parents Are Vital in Education (PAVE), representing East and West, and/or rural and urban)

The TWG will be comprised of a minimum of 25% consumers and family members. In addition to the main decision-making body, there will be eight standing sub-committees where tasks, goals and implementation plans will be identified, then brought to the TWG for execution: 1) children and youth, 2) parents and families, 3) youth transitioning into adulthood, 4) adult consumers, 5) older adult, 6) homeless people, 7) criminal offender population, and 8) co-occurring disorders. Each subcommittee will be co-chaired by a high-ranking state official who wields decision-making authority and by a consumer. Furthermore, each committee will be comprised of at least 51% consumers and consumer family members.

This level of participation by consumers is unprecedented in Washington. While efforts at including consumers and families in the administration of mental health care has been growing in the state over the past several years, the assessment of needs and the consumer input that were collected for this proposal's planning process made it clear that these efforts are not enough. A much more thoroughly consumer and family-centered orientation to mental health service design and policy development is called for and will set the stage for fundamental change.

Consumer Evaluation of the Transformation

The Washington State Legislature has mandated that DSHS-MHD implement a statewide mental health outcomes system to improve care, to which the Mental Health Division has responded with a comprehensive consumer outcome measurement system. MHD is beginning to use consumer-reported outcomes to increase the effectiveness, efficiency and quality of the public mental health system. With the recognition that administrators are removed from the day to day lives of consumers, this consumer outcome measurement system is meant to open lines of communication from consumers to administrators. By listening to consumers as they move through treatment, administrators and the TWG can improve mental health service delivery and to ultimately reduce psychological distress and improve the quality of life of mental health consumers.

The Mental Health Division has used the survey instruments recommended by MHSIP (Mental Health Statistical Improvement Project) to inquire about service recipients' perceived general satisfaction with services, voice in service delivery, satisfaction with staff, perception of outcome of services, access to services, and staff sensitivity to culture. These items correspond to the information needed for Washington State's Performance Indicator Project and satisfy the federal CMS requirements. Also included are pertinent demographic questions including employment information, as well as inquiry to determine whether the client receives Medicaid health insurance. Respondents were also asked for their comments regarding services or their experiences. The sample for the survey is drawn from the Mental Health Division's Management Information System. The sampling was conducted immediately prior to these periodic surveys. The survey generally targets a total statewide sample of about 3,000 individuals, with an approximate 33% response rate.

This evaluation system creates a meaningful opportunity for consumers to be partners in the evaluation of the programs that serve them. The consumer-centered instruments increase consumer involvement and facilitate self-education. But consumer involvement will now go beyond that so that

consumers will not only be involved in providing information for the evaluation, they will also be involved *as evaluators*. Consumer consultants will be brought in who can help interpret data and contribute to a process evaluation to ensure that the consumer voice is not lost in the course of analyzing data. The reports that are produced from the satisfaction surveys will also now be summarized for consumers and families, so that they may make informed decisions about the array of services available. These summaries will be simple, easy-to-read brochure-style materials with a report-card format demonstrating varying outcome measures, satisfaction ratings and other features of the various services that have been evaluated. The evaluation design for the ongoing TSIG process, which is described below, also has a significant place for consumer-researchers.

Consumer Involvement and Sustaining the Transformation

The sustainability of the Transformation is contingent upon the State's ability to maintain the engagement and involvement of family members and consumers. Without their continued support, the vision for the Transformation is meaningless. The most effective way to ensure that support is by forging strong relationships with statewide organizations of consumers and family members.

In the state of Washington, there is a strong coordinated statewide network of parents and family members of mental health consumers. The 26 local chapters of the National Alliance for the Mentally Ill (NAMI) work together through the State chapter of NAMI to support family, friends and consumers, and to advocate in the legislative, executive, and judicial branches of State government. In addition to NAMI is the Statewide Action for Family Empowerment of Washington (SAFE WA), an active consortium of 22 family and youth consumer advocacy organizations. Another organized group is Parents are Vital in Education (PAVE), an advocacy group of family members of children and youth with SED. Many of the individuals whose input has contributed to this proposal are members of NAMI, SAFE WA and PAVE, and these organizations will continue to be a resource in the development and implementation of the CMHP. Members of NAMI, SAFE WA and PAVE will sit on and sometimes chair the eight sub-committees mentioned above.

A coordinated statewide network of adult primary consumers is not currently found in Washington, but there are several smaller adult consumer groups whose development is pivotal to Partnerships for Recovery. The Clubhouse Association is among the most noteworthy of these groups. Additionally, the Office of Consumer Affairs within the Mental Health Division (MHD) has developed the Consumer Roundtable, which brings together consumer leaders from across the state to encourage networking and support of individual RSN consumer initiatives. The Consumer Roundtable, the Clubhouse Association and many smaller grassroots consumer groups are needed to solidify the consumer leadership base in the state, but consumer leadership at the local and statewide level must be further cultivated. Locally-based organizations, such as Clubhouses and Regional Support Networks, are in a good position to encourage grassroots development, but they must be armed with technical assistance and resources to accomplish this important goal.

Another way that more statewide consumer involvement and organizing can be fostered is through an annual Consumer Conference, which will be organized by the TWG in collaboration with MHD's Office of Consumer Affairs and the Consumer Roundtable.

Consumer-leadership development is necessary to fulfill several goals set forth in the President's New Freedom Commission Report on Mental Health. They include Goals 1, 2, and 4. In addition, a transforming system, no matter where it is on a change-curve, cannot be successful without a consumer community that contains leaders, innovative programs for recovery, and a strong organizing vehicle to ensure leadership development. Stagnant mental health systems generally rely on the same consumers to serve or to speak. The CMHP will spark new thinking in the way of consumer leadership and sustenance of a transforming consumer movement in Washington State.

How TWG Chairperson Interfaces with the Governor and with the TWG

The Chairperson of the TWG will oversee all Transformation activities, and will preside over the creation and execution of the Comprehensive Mental Health Plan. SHe will have a weekly briefing session with the Governor where he will apprise her of TWG and CMHP progress and request endorsements, assistance, and policy inquiries as needed. He will attend all TWG meetings, and will receive quarterly reports from each of the eight sub-committees. Each TWG member will have an individual meeting with the Chairperson once every 12 months. These will be scheduled throughout

the year. The Chairperson will also be the public face of the Transformation, heading up the public awareness stigma-reducing campaign, opening public forums, and speaking with the press and at other public venues. In this public position, he will represent the activities of the TWG to the public, thereby adding another level of accountability to the Chairperson and to the TWG.

Needs Assessment and Inventory of Resources Strategy

Needs Assessment: Building on our resource inventory and the kick-off activities of April 13, 2005 we will broaden and deepen our statewide needs assessment so that our CMHS plan responds to the needs of our State's population. The needs assessment will involve consumers and family members to ensure that the experiences of consumers and family members are clearly heard and reflected in the findings and recommendations that are derived from the needs assessment.

- The TWG will issue guidelines for position papers from stakeholder groups from around the State. These documents will be solicited from the academic institutions, community based organizations, local governmental organizations, faith-based organizations, and consumer and family organizations.
- Consumer and family organizations will be invited to organize focus groups in which the planning staff will solicit information on needs, barriers, and opportunities. Funds will be made available for organizations to support consumers and families for the costs of transportation, childcare and to pay for refreshments or food for the focus group.
- The State's web site currently hosts a questionnaire for consumers, family members, community-based organizations and other stakeholders to fill out regarding system needs. The TWG will ensure that the existence of this website and survey is widely disseminated.
- The TWG will hold two "listening sessions" in each of the 14 RSNs. These sessions will be organized by the RSNs; both sessions in an RSN will occur on the same day with one session devoted to feedback from consumers and one from line staff of service provider agencies.

Resources Inventory: The resource inventory will become an ongoing process, rather than a one-time research project. During the first three months of the Partnerships for Recovery, planning staff will work with each of the participating departments to conduct an exhaustive inventory of resources devoted to serving SMI adults and SED children and youth. The inventory will obtain data by examining departmental budgets, organization charts, and proposals, supplemented by interviews with key managers, and finally, by a survey completed by each of the RSNs. Major elements of the information collected will include:

- Funding and funding sources for services for SMI/SED individuals;
- Programmatic resources for SMI/SED individuals, including program descriptions, staffing, office locations, contact phone number, number of professional and support staff and number of consumers served annually.

This information will be assembled into a database that will then be used, in the first instance, to create a statewide mental health resource inventory. In addition to a traditional paper report and executive summary for TWG, Partnerships for Recovery will produce two web-based data interfaces:

- A planning interface that will allow the information to be cross-tabbed by geography, funding source, age group(s) of the target population, and program purpose, with available measurement units being funding amounts, number of staff, and number of individuals served. We will also estimate regional prevalence by age group and design the software to report on penetration rates.
- A searchable, statewide mental health services inventory with an interface designed for individuals seeking mental health-related services in their areas.

Both of these applications will be made available to the public on the DSHS Website. This inventory will be updated annually, with an annual summary provided to the Governor, the Legislature and the MHPAC. This document will clarify the level of resources devoted to mental health-related services by each department, funding source, and region, and – as this process continues – track longitudinal trends. Over time, we believe that this process will become more refined and more useful, and will become an integral element in the state budgetary and planning process.

Developing the Comprehensive Mental Health Plan

Partnerships for Recovery's strategic planning process is designed with the following principles, derived from the mental health transformation goals set forth by the President's New Freedom

Commission on Mental Health:

- Authentic involvement of mental health consumers and their families as full partners in the State's development of the Comprehensive Mental Health Plan.
- A planning process that promotes health and upholds the wellness/recovery-oriented and transformative vision of the New Freedom Commission.
- A comprehensive process that takes a cross-system approach, which includes broad representation of stakeholders outside the traditional State mental health agency.
- Extended dialogue and an open, accountable, transparent and productive planning process.

The Comprehensive Mental Health Plan (CMHP) will evolve through a series of four phases during the planning year. The first two phases, occupying six months, will be coextensive with the needs assessment and resource inventory described in the immediately preceding section.

Phase 1: Development of Vision Statement and Outcome Measures (Months 1 and 2)

Deliverables:

- Vision Statement for the Transformation Process
- Outcomes identified in the following 8 areas
  - 1) Children and youth
  - 2) Families
  - 3) Youth transitioning into adulthood
  - 4) Adult consumers
  - 5) Older adult consumers
  - 6) Homeless people
  - 7) Criminal justice/mentally ill offender population
  - 8) People with co-occurring mental health & substance abuse disorders

In month 1, the TWG will refine the vision statement to guide the transformation process and will organize subcommittees in each of the 8 subject areas identified above. Each of these subcommittees will be co-chaired by a high-ranking state official who wields decision-making authority from the TWG and by a consumer, with invited participation from consumers and subject area experts from around the state. In the second planning month, these subcommittees will meet and will draft outcome objectives consistent with the Initiative's Vision Statement. Over the course of the next year, the TWG will continue to meet monthly to oversee progress and to provide a unifying perspective on all of the particular focused planning efforts underway.

Phase 2: Qualitative data collection (Months 3-5)

Deliverables

- Peer-to-peer interviews with 1000 primary consumers and 500 family members
- Random digit dial survey of 1000 respondents

Peer Consumer Interviews: In our experience, there is no substitute for simple, extended, one-to-one conversations with consumers (both primary consumers and those who care about them). As part of the needs assessment process, Washington will implement a peer-to-peer interviewing process. In this phase of the process, we will train 50 mental health consumers and 25 family members (referred by community mental health or advocacy organizations) to conduct structured, open-ended interviews with approximately 1000 clients (covering the age spectrum from adolescence to older adulthood) and 500 family members. Interviews will be set up on a voluntary basis in mental health outpatient clinics and community organizations. We will aim to conduct interviews of approximately one hour in length, soliciting structured feedback on needs, experiences, barriers, and opportunities. Interview questions will be vetted with the TWG. Both interviewers and interviewees will be paid. Interviewee's names will not be recorded. We have found that this peer interviewing approach has a number of significant advantages:

- It provides a detailed body of structured narrative information to set beside quantitative and research data.
- It serves as a community mobilization tool. We expect that, when we organize meetings to review strategic plans in the later phases, both community interviewers and their interviewees will become participants in the ongoing planning.
- It provides the planning process with a level of credibility that could not be achieved with more traditional methods. Through this process, the clients and family members themselves become planners rather than merely objects of inquiry by others who are planning on their behalf.

Random digit dial survey: Whereas the peer interviews will be the basis for examining the views

of current mental health consumers, a 1000-respondent random-digit dial telephone survey will be the basis for developing the social marketing and anti stigma plans. This survey will be conducted both day and evening hours, in all of Washington's threshold languages. The survey will assess population attitudes and experience with mental illness and with the mental health system. It will ask about attitudes toward treatment and recovery. It will assess attitudes on key social policy issues such as homeless and incarceration among mentally ill individuals.

Phase 3: Alignment (Months 6-9)

Deliverables
- Alignment planning in the following areas
  1) Evidence based practices
  2) Management information systems
  3) Fiscal systems
  4) Social Marketing
  5) Cultural Competence
  6) Evaluation

The Initiative will assemble task forces of subject area experts in each of the following areas to identify systems and capacities that need to be developed or strengthened to achieve the outcomes and the vision identified in Phase 1. Each of these task forces will identify 1-3 key initiatives that should be undertaken in the Transformation effort and will develop four-year strategic plans for implementing them.

Phase 4: Plan development (Months 10-11)

Deliverables:
- Draft Comprehensive Mental Health Plan

During this phase, Initiative staff will work to shape all the information collected during the prior phases into a Draft Comprehensive Mental Health Plan. Staff will draw heavily on individuals who have participated in the prior planning phases. The plans developed by the individual planning bodies will need to be pruned and shaped to create a coherent strategic plan that can achieve the Transformation vision. Ultimately the final shaper of the plan will be TWG chair and the Governor.

Phase 5: Completed Comprehensive Mental Health Plan (Month 12)

Deliverables
- Completed Comprehensive Mental Health Plan

In this phase, the TWG will convene to finalize the CMHP and forward it to the Governor for her review, modification, and approval. The completed Partnerships for Recovery Comprehensive Mental Health Plan will include a vision & strategy that provides:

- Vision statements & objectives
- Action plans
- Monitoring and reporting methodology
- Identification of linkages and responsibilities
- Identification of opportunities and priorities
- Plans for anti-stigma and social marketing campaigns
- Workplan for the subsequent four years
- Budgets for the initiative
- Needs assessment and resource inventory
- A focus on the individual or more specific needs and desires of local communities.

Strategy for Linking the MHT-SIG to Other Appropriate Grants in the State

Mental Health services in Washington are by and large paid for through Medicaid. With 89% of public funds used to treat mental illness coming from Medicaid, Washington relies heavily on Medicaid. While the State's ability to leverage this resource for mental health care has been enormously helpful, it also comes with a downside. Payment through Medicaid can be rigid, and the Transformation hinges upon flexibility, putting the State in a difficult position as it attempts to address financing issues through coordination, alignment, pooling, and/or braiding of funding streams. One concept that will be investigated by the TWG is how to maximize federal funding while freeing up other funds to serve mental health needs more flexibly. A first step will involve analyzing the state/federal partnership of Medicaid with a particular eye toward dividing out multi-use funds, coordinating with the Mental Health Block Grant (MHBG), and linking with other grant-funded programs throughout

the state. To the extent that is appropriate and allowable, resources will be creatively braided to execute dimensions of the CMHP. Wherever goals are aligned with the Transformation, corresponding activities will dovetail with CMHP activities for more efficient use of resources and energy.

The goals of the MHBG are consistent with Partnerships for Recovery including the increased involvement of consumers and families, the improvement of cultural competency, enhanced coordination among agencies that serve mental health consumers, and the general improvement of access to and delivery of services. The coordination begins with the special relationship that will exist between the TWG and the MHPAC, and succeeds naturally as the lead agency of the MHBG is the Mental Health Division, and the MHD director will be sitting on the TWG. Since the MHT SIG is dedicated entirely to transforming the infrastructure for how mental health services are administered and delivered, and is not concerned with funding direct services, coordination between these two agendas will be efficient and non-duplicative.

Among the other anticipated grants to which the MHT SIG will link are the SAMHSA-funded programs operating in Clark and King Counties. These programs have paved the way for an integrated system of care for children and youth consumers. Coordination with the Transformation effort is essential as these programs offer a wealth of knowledge on how systems can be integrated and resources reinvested in more consumer-oriented care.

Another is Washington State's Strategic Prevention Framework State Incentive Grant (SPF SIG), led by DASA. The SPF SIG allows for the improvement of assessment processes, implementation and evaluation of evidence-based strategies to address critical needs based on epidemiological data, and establishment of reporting procedures that track progress toward preventing alcohol, tobacco, and other drug use and abuse and related problems, including mental illness, delinquency, and violence. These activities are very much in keeping with the Transformation's goals of developing a data infrastructure for a more efficient and effective evaluation and feedback loop.

The MHT SIG will also coordinate with Western State Hospital's SAMHSA-funded Project to Reduce Violence and Eliminate Seclusion and Restraint, an initiative to reduce violence, promote recovery, and eliminate seclusion/restraint in the care of mental health patients. This initiative involves extensive research on EBPs for nonviolent treatment, and it requires multiple levels of staff training and infrastructural change. These activities are already underway and will provide meaningful input towards Partnerships for Recovery's goal of ensuring the least restrictive environment for mental health care. Several consultants and MHD staff will be concurrently involved in both programs, for smooth coordination of knowledge and agendas.

Enhancing the cultural competency of mental health services vis-à-vis tribal populations is a priority for all State agencies participating in the TWG. The SAMHSA-funded program currently being operated by the Pullayup tribe, for example, will provide Partnerships for Recovery with valuable data and insight on culturally-responsive mental health approaches. Partnerships for Recovery will also coordinate with DSHS's current efforts to enhance partnerships and contracts between State agencies and local tribes. Four Tribes are currently contracting with the department under this collaborative process: Upper Skagit, Nooksack, Lummi, and Tulalip Tribes.

Developing Individualized Recovery Plans with Full Consumer Partnership

A principal goal of the Comprehensive Mental Health Plan will be to ensure that all consumers are part of the development of their own Individualized Recovery Plans. Patients are to become actively involved n their treatment plans, with the underlying notion that a consumer's success depends on her own involvement in her recovery and in her ability to develop her skills. Individualized treatment planning for individual recovery entails reaching people where they are receiving services, which means that the plans must be developed wherever the consumer is located, be that in a homeless shelter, in an outpatient clinic, in a mental hospital, or in a juvenile rehabilitation facility. Below are a number of specific strategies that will be used to make sure that consumer involvement is legitimate and fosters partnership in recovery.

Consumers Will be Educated: Consumers want to be full partners in recovery, yet mental health systems have generally not been oriented in this regard. In preparation for this new role, trainings on consumer involvement will be offered by peer educators. Curriculum for these trainings will be developed using CMHS's Recovery Series by Mary Ellen Copeland (e.g., *Wellness Recovery Action Plan*, *Speaking Out for Yourself*, etc.). The booklets are handy educational tools, written in 4-6

grade-reading levels. The booklets are the bases for providing consumers with information that can help them become better self-advocates and partners in their own recover.

Statewide Peer Counselor Programs Will Grow: Consumer empowerment will be enhanced if there are more opportunities for consumers to be trained and credentialed as peer counselors. Not only will it give a consumer mentors to look to as exemplars, it will provide him a viable option for where to go once his recovery had progressed. The model at Western State Hospital is to have one consumer working on every ward, on every shift. Western is working to make reality, but it serves as an example of how this idea can be put to work for the consumer. Partnerships for Recovery will draw on the current literature (Hoagwood 2005) to build greater resources peer professional programming and family-based services.

More Continuity of Care Will Be Established: A crucial issue for mental health in the state of Washington is serving the consumer through his various transitions. A child consumer transitions into the juvenile system; that juvenile may transition into an adult system; juveniles and adults both transition from confined settings to outpatient care; and adults and families transition out of homelessness. An individualized care plan needs to take these movements into account, and create as smooth a transition for the consumer as is possible. For example, when moving from an incarcerated setting or hospitalization into the community, there can be a delay in the availability of medication – something which can have dire results. A more coordinated system that puts the consumer at the center will prevent this from happening. This more coordinated system will require cooperation from community providers, which can pose obstacles, typically resistant to taking state hospital patients. In the Transformation, release will be tied with Olmstead, and a treatment plan will include a comprehensive and well-coordinated discharge plan.

Staff Will be Trained: The idea of full partnership for consumers in their recovery will be a welcome approach for some care staff, while for others it will be a radical departure from how they are accustomed to doing their jobs. In order to minimize resistance to the consumer- empowered approach, staff will be offered training that will focus on the recovery model and its success through full consumer partnership. A useful tool in this training will be the film, *Inside/Outside: Building a Meaningful Life After the Hospital*. The expectation is that with increased empathy and a better understanding of the power of full partnership, staff will be more open to a new approach.

Section D: Sustainability

Partnerships for Recovery is proposing a transformation effort that will continue beyond the grant period. We are building the infrastructure to an ongoing process of planning, action, learning and innovation. (Lewin, 1951) (Kuhn, 1962) (Sugarman, 2000) We will implement a comprehensive approach to ensure our ongoing capacity to sustain Partnerships for Recovery on both the state and the local level. Elements of this plan include:

Sustainable Infrastructure Development

Elements of permanent infrastructure development will be 1) expanded consumer, youth, and family organizations that will be more connected to each other across the state and a stronger policy voice, 2) increased knowledge and skills on the part of consumers and family members regarding evaluation and the use of data for accountability, and 3) a cadre of university faculty who are consumer and family friendly and able to support consumer exploration and voice in policy matters.

In the arena of technology, we will expand the existing data warehouse to include additional agencies and expanded data and will enhance the front-end to provide real-time accessibility to a broader range of users. Coordinated training of managers and policy makers in the use of this data system for planning, resource allocation and management will provide a sustained benefit. Secondly we will develop a web-based HIPAA-compliant electronic medical record that will provide the foundation for a generation of regional management information systems. Thirdly, the implementation of web-based consumer satisfaction surveys and web-based publicly accessible outcome reporting provide the informational basis to create a culture of accountability which is one of the principal results the Washington Partnerships for Recovery is attempting to develop.

Section D describes how the Resource Inventory will become an ongoing policy tool integrated into the legislative budget process. In the same way that “Children’s Budgets” have become re-

sources for advocates and planners to understand and expand resources provided for children, so the "Resource Inventory" will become an ongoing tool for consumers, advocates, and planners alike.

Sustainable Practice Improvements

The extensive statewide training on the Recovery Model, including comprehensive assessment, mobilization, strategic planning, implementation of evidenced-based programs and practices, and meaningful local evaluation, will build community capacity that will benefit the state system for many years to come. Equally important, Partnerships for Recovery will develop a statewide registry of evidence-based, reimbursable practices, combined with fiscal incentives and minimum compliance standards for the use of EBPs. This set of reforms is intended to be a permanent transformation of the way mental health services are practices and paid for in the state of Washington. The use of Individualized Recovery Plans, combined with training on WRAP, wrap-around, and other evidence-based care planning practices represent another enduring practice improvement that will be adopted statewide as a result of this project.

Increased Public Awareness and Support

The Anti-Stigma and Suicide Prevention campaigns will raise the level of public awareness and support for mental health funding that will endure after the end of grant funding. Similarly, Strengthen the statewide consumer and family member advocacy infrastructure will create a network on the ground to sustain consumer and family member involvement in and advocacy for the Transformation process and the Transformed system.

Enhanced Consumer Orientation and Cultural Competence

The Initiative plans a comprehensive transformation of the role of consumers in the service system. This includes rewriting job descriptions and service delivery modes to ensure that there is an entry point for consumers into employment in mental health services, and that there is a career ladder by which they can move up to become managers and directors of the system. Secondly, the efforts to establish training and certification programs in the community colleges for behavioral health consumer-professionals will ensure that there is a pool of trained consumers to fill the new positions being created. The State will mandate expanded consumer participation on advisory and oversight boards at the state and local levels as well as within direct service delivery programs. New standards for cultural competence will also be designed and will be supported by inclusion of cultural competence as an aspect of the quality assurance process. Each of these changes, once accomplished, is enduring and is not dependent on ongoing SIG funding.

Revenue Enhancements

Washington is fortunate in having most of its behavioral health services integrated into a single Department, the Department of Social and Health Services. Under this Initiative, DSHS will use its oversight to help to integrate and blend funding for individuals with mental health problems and will work to recapture and reinvest funding, particularly Medicaid funding, into effective, integrated recovery oriented practices. A pilot project underway in Snohomish County, the Washington Medicaid Integration Partnership (WMIP), provides a model for this. WMIP is integrating medical care, mental health care, and substance abuse treatment into an integrated managed care system, which is hoped to become a replication model for the rest of the state.

The overall state mental health system, in which Regional Support Networks are fully capitated, provides an excellent environment for sustaining effective practices developed through this initiative. One of the more complex aspects will be blending Medicaid funding for substance abuse treatment with that for mental health treatment for consumers with co-occurring disorders. The Initiative is aiming to address regulatory and systemic barriers to achieving blended funding, dual licensing, and integrated charting. By more effectively serving this most costly and problematic population, it is hoped that the state will be able to recapture and reinvest funds into Transformed model services.

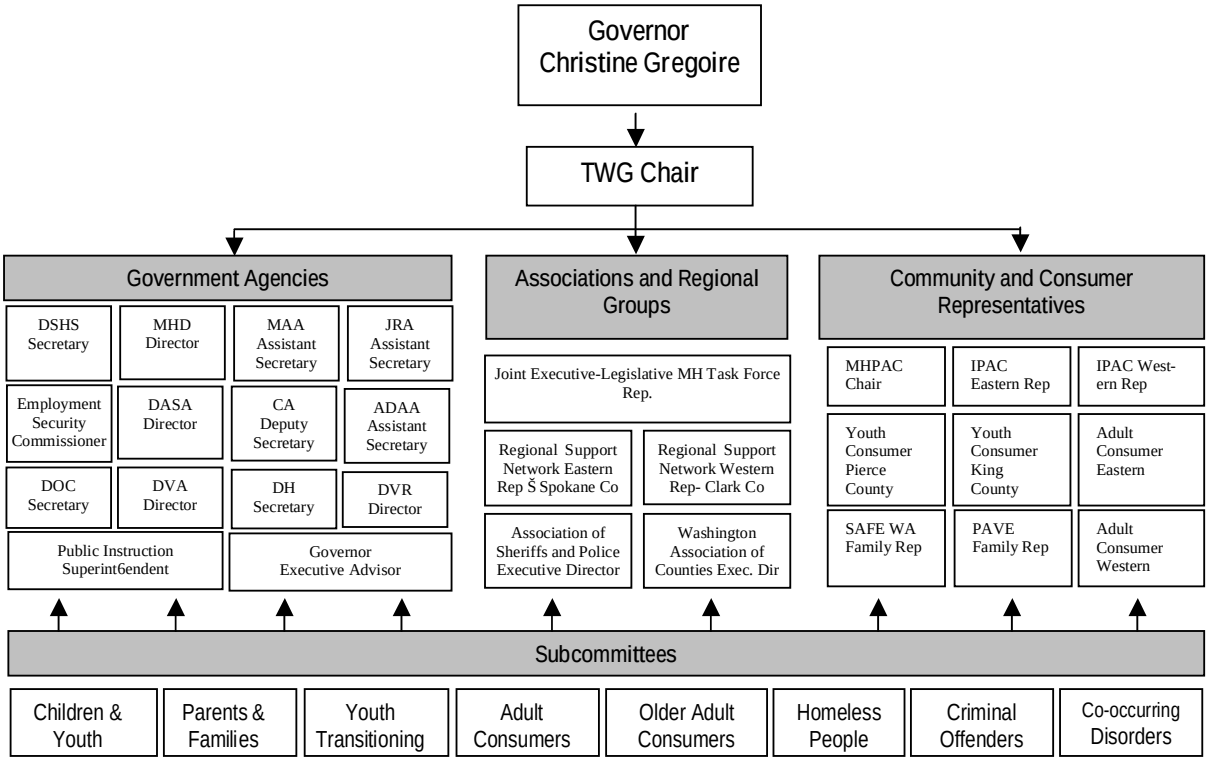
Governance

The state-level governance system will also be sustainable, as the TWG will continue after SIG funding expires. Since this group is formed as an expanded version of the State Mental Health Council, the state partners are confident that they will continue to meet regularly after the end of the SIG.

Section E: Staff Management and Relevant Experience

Chairperson's Vision and Leadership

Cheri Dolezal's vision, for mental health to be consumer-centered, and recovery-based, began



when she was only 18, volunteering at a center for developmentally disabled children. From that point forward, her commitment to service blossomed, and her diverse career began. During the past 30 years, she has been a specialist in geriatric mental health, children's mental health, substance abuse recovery, nutrition, and legislative procedures. Her appreciation for the interconnectedness of mental health systems is unique, informed by these experiences and by her perceptive nature. With an eye toward eliminating redundancy and increasing communication, Ms. Dolezal's ultimate aim is to facilitate the recovery of the state's mental health consumers through supported self-empowerment and efficacious treatment. To do this, she will lead the disparate members of the TWG as a steward, ensuring that quiet voices are heard, and that common points are emphasized. By putting the consumer at the center of the Transformation vision, Ms. Dolezal can help bring incongruent positions into congruence, reminding all participants that they share a common concern for the recovery of the state's consumers of mental health.

TWG Participants, Roles and Commitments

Governor Gregoire's Transformation Working Group (TWG) is made up of highly skilled leaders from state offices, consumer and family-based organizations and regional agencies whose highest priorities include the public's mental, behavioral and emotional health. Each of these member's' prior experience in the development of effective systems or participation in successful collaborative initiatives indicates their ability to work cooperatively with a diverse group of stakeholders and demonstrates their commitment to fundamentally changing the mental health system. As documented in their memoranda of understanding and letters of commitment, each member will exert a high level of effort to support the Initiative's success utilizing their resources and expertise.

Roles for TWG Members from Selected State Offices, Divisions or Agencies

To ensure the transformation of the mental health services system, senior leaders from State Offices, Divisions or Agencies will serve on the TWG. These members will function as representatives of their specific departments, while also working as collaborative team to improve services for con-

sumers and family members across all systems. Governor Gregoire will oversee the Partnerships for Recovery effort, informed by the eight subcommittees that focus on specific consumer populations.

As documented in the Memorandum of Understanding in Appendix 1, their primary roles, responsibilities and level of effort include:

- Conduct a needs assessment of their department;
- Complete a comprehensive resource inventory;
- Identify ways to make systems change within their departments and with others;
- Align services for consumers and family members in each connected system;
- Devote in kind resources to support TWG efforts;
- Pledge staff participation in all training, planning, and evaluation efforts;
- Participate in shared enhancement activities for participant data collection and analysis;
- Help facilitate communication between the TWG, agency staff and contractors, local service providers, consumers, family members, youth and older adults;
- Engage advisory committees in Transformation efforts by keeping them informed, and seeking their input; and
- Participate in the common evaluation and provide the necessary data.

Office of the Governor, Executive Policy Advisor Kari Burrell

Qualifications: Over the last four years, Kari Burrell has served as a policy advisor on issues affecting vulnerable children and adults, including: child welfare, homelessness, mental health, developmental disabilities, long-term care, and veterans' services. In both her prior positions as a public policy consultant, she has been an instrumental figure in transforming human services-based initiatives including Nevada's Department of Family and Youth Services' reorganization of its juvenile justice and child welfare programs; change management for Wisconsin's W-2 welfare reform initiative; and management improvement review for Washington State's Children's Administration.

Commitment to Transformation: Kari Burrell will represent the Governor on the TWG and her priorities and will support continuous communication between the Governor and the TWG in conjunction with the Chair. She will also work to ensure collaboration between the state departments and agencies and help them align services for consumers in each system. This will be written by the governor's office in as an official duty of Executive Policy Advisor.

Department of Social and Health Services, *Secretary Robin Arnold-Williams*

Qualifications: Dr. Arnold-Williams comes to Washington from a notable seven-year tenure as Executive Director of the Department of Human Services in Utah. Among her key concerns in Utah was child welfare, especially looking past the limitations of federal financing for children's physical and mental health, to a more flexible and more collaborative approach to improve outcomes for the children and families. Given the financial challenge in the state of Washington, the collaborative nature of the Transformation, and her key position over eight individual sub-organizations that are TWG participants, Dr. Arnold-Williams's contribution to the TWG will be invaluable.

Commitment to Transformation: Dr. Arnold-Williams commits to sit on the TWG, and to make directives to the eight TWG participating Administrations and Divisions that are housed within DSHS, as formulating and executing the CMHP requires.

Health and Rehabilitative Services Administration (HRSA), Assistant Secretary Tim Brown

Qualifications: Dr. Timothy Brown has served as Assistant Secretary since July 2000, and is responsible for the direction and administrative oversight of programs within the Division of Vocational Rehabilitation, Mental Health Division, Division of Alcohol and Substance Abuse, Office of Deaf and Hard of Hearing and the Special Commitment Center. Dr. Brown has served as both the Chief and Director of the Office of Research, as well as holding the positions of Rainier School Superintendent and Director of the Division of Developmental Disabilities. He obtained his Ph.D. in Clinical Psychology from the University of Oregon, and serves as both HRSA Assistant Secretary and MHD Director.

Commitment to Transformation: MHD, housed within HRSA under Dr. Brown's direction, will serve as the lead agency for the Transformation, and HRSA will commit necessary resources to fulfill its leadership tasks, including administration of the grant and budget oversight.

Division of Vocational Rehabilitation (DVR), Director Michael O'Brien

Qualifications: Director O'Brien is a certified Rehabilitation Counselor and Vocational Evaluation

Specialist who possesses more than twenty-five years experience in the public and private sectors. In addition, he has earned an Ed.D. in Occupational and Adult Education and a Masters degree in Career and Vocational Guidance. Through research for the Institute for Rehabilitation Issues' (IRI) projects on Distance Education in Rehabilitation and Consumer Organizations and Their Contributions to the Public Vocational Rehabilitation Program, O'Brien has learned about the Consumer Movement and increased his division's involvement in the community.

Commitment to Transformation: DVR will provide a 0.5 FTE staff member to assist in Initiative coordination and implementation and in the cultivation of the Clubhouse movement.

Division of Alcohol and Substance Abuse (DASA), Director Ken Stark

Qualifications: Director Stark has built his impressive career on the principle of effective treatment and strong leadership. His numerous state and national appointments illustrate his accomplishments. Mr. Stark is currently the Research Committee Chair and Region X Director for the National Association of Alcoholism and Drug Abuse Directors and serves on the National Advisory Council of SAMHSA, as well as on its National Committee for Women's Services. He has received the Governor's Sustaining Leadership Award and a variety of honors from provider associations.

Commitment to Transformation: DASA will provide a 0.5 FTE staff member to help implement Initiative activities related to AOD issues and to support data infrastructure development.

Medical Assistance Administration (MAA), Assistant Secretary Doug Porter

Qualifications: Assistant Secretary Porter has made transformation happen in many systems. Prior to assuming leadership of Washington's Medicaid program in 2001, Porter headed California's Medicaid program where he was responsible for expanding mandatory enrollment of 2.5 million beneficiaries into managed care. He also coordinated eligibility and outreach efforts for children in Medi-Cal with the new SCHIP program "Healthy Families." Director Porter currently serves on the Executive Committee of the National Association of State Medicaid Directors (NASMD) and chairs that organization's Technical Advisory Group (TAG) on Medicare and Medicaid issues.

Commitment to Transformation: MAA will provide 3.0 FTE's to assist in the Initiative coordination and implementation equivalent to $200,000 annually.

Children's Administration (CA), Assistant Secretary Cheryl Stephani

Qualifications: Assistant Secretary Stephani's recent appointment in April 2005 to the Children's Administration reflects her success in leadership within the Department of Social and Health Services (DSHS) and her outstanding efforts in advocacy for children's services. Prior to this appointment, she served as the Assistant Secretary for the Juvenile Rehabilitation Administration (JRA) for five years and served as special assistant to two former DSHS secretaries for over six years specializing in children's issues and organizational management.

Commitment to Transformation: The Children's Administration commits Secretary's Stephani's participation on the TWG and to treatment coordination for children who are multi-system clients within their own system, the mental health system, and juvenile rehabilitation, to train staff according to the CMHP, and to align procedures to the Transformation.

Juvenile Rehabilitation Administration (JRA), Acting Assistant Secretary Robin Cummings

Qualifications: Acting Assistant Secretary Cummings' in-depth knowledge of the Juvenile Rehabilitation system facilitates her department's focus on service integration and use of evidence-based practices. Before assuming her current position in May 2005, Cummings was the Director of the Division of Institution Programs where she was responsible for implementing the new evidence-based integrated treatment model which empowers youth through learning about their own behavioral change. In her other prior positions as Director of Community Programs and Deputy Director of the Office of Program Development, she also implemented model treatment approaches including Functional Family Therapy and Multi-Systemic Therapy. The value the Assistant Secretary places on best practices and her experience in their implementation will prove invaluable to the TWG as it assesses how to improve services through evidence-based approaches.

Commitment to Transformation: Since March 2000, JRA has been actively pursuing implementation of research-based interventions for youth in the deep-end of Washington State's juvenile justice system. In 2002, an integrated treatment model was piloted. It has now been adopted across the JRA system coaching and mentoring youth in the use of cognitive behavioral skills while in residential care and working with family systems as the youth returns home. JRA commits to participate in and

execute TWG efforts in staff training, intake and assessment and consumer-centered approaches.

Aging and Disability Services Administration (ADSA), Assistant Secretary Kathy Leitch

Qualifications: As a twenty-seven year veteran within DSHS, Assistant Secretary Leitch brings award winning management skills and policy-making experience to the Initiative. She was Director of the Home and Community Services Division within Aging & Adult Services which helped increase home and community-based options for persons with disabilities and reduce the number of Medicaid residents in nursing homes in Washington. Her efforts have been recognized at both the national and state levels. She is the First Vice President for the National Association of State Units on Aging; was a board member with the National Academy for State Health Policy and was selected as a Sustaining Leader for the 2001 Governor's Distinguished Management Leadership Award.

Commitment to Transformation: Secretary Leitch will sit on the TWG. As a part of ADSA's commitment, the department will implement and monitor crisis protocols, provide mental health training for ADSA providers and staff and enhance ADSA residential MH services.

Department of Corrections, Secretary Harold Clarke

Qualifications: Secretary Clarke's active involvement in his field's associations illustrate his inherent leadership qualities as well as his awareness of policies and approaches at the national level. He currently serves as the Vice President of the American Correctional Association and was a past member of the American Correctional Association's Board of Governors and as well as Vice-Chair of the Association's Ethics Committee. He has consulted for the National Institute of Corrections and other branches of the U.S. Department of Justice. With this level of connection, Clarke will ensure that the Initiative acts in accordance with the most effective and recognized practices.

Commitment to Transformation: Secretary Clarke will sit on the TWG, and DOC will evaluate evidence based assessment tools and referral protocols regarding the domains of mental illness, chemical dependency and other related factors.

Department of Veteran's Affairs, Director John King

Qualifications: Director King's experience makes him a highly qualified member of the TWG. King served as Director of the Department of Veteran's Affairs for eight years and prior to this post, as Deputy Director of Administration for the Attorney General's Office for two years. As a Vietnam veteran, he was awarded a Bronze Star and earned a Masters in Social Work Administration. His receipt of the Governor's Distinguished Management Leadership Award and his recent completion of Harvard's Executive Management Program illustrate his skill in management and administration.

Commitment to Transformation: Under the leadership of Director King, the Department of Veteran's Affairs has promoted mental health and wellness for the state's more than 670,000 veterans. The Department's services include three Medicaid certified residential veterans homes and a network of counseling sites throughout the state.

Department of Health, Secretary Mary Selecky

Qualifications: Throughout her career, Secretary Selecky has been a leader in developing local, state and national public health policies that recognize the unique health care challenges facing both urban and rural communities. She is also known for bringing people and organizations together through successful initiatives to improve the public health system and the health of people in Washington State. Selecky has been the Secretary of Department of Health since March 1999. In February 2005, she was reappointed to the position by Governor Christine Gregoire after serving almost six years as secretary under Governor Gary Locke. Secretary Selecky is past president of the Association of State and Territorial Health Officials and was awarded the 2004 McCormack Award for excellence in public health.

Commitment to Transformation: The Department of Health's commitment to transformation is evident in their existing collaborations that promote systemic change and wellness for the residents of Washington. The Department of Health is a key partner in the State Epidemiological Workgroup, which works with four other TWG members' departments to provide the resources necessary to track progress toward preventing alcohol, tobacco, and other drug use and abuse. They play a significant role in the Safe Babies, Safe Moms Initiative with other TWG Members which provides services to substance-abusing pregnant and parenting women and children 0-3.

Department of Public Instruction, State Superintendent Terry Bergeson

Qualifications: Dr. Bergeson's efforts prove her to be a proponent of systemic change and citizen

involvement. For more than 35 years, Dr. Bergeson has focused on what is best for students, and has worked tirelessly to build partnerships between legislators, educators, and parents and community leaders. As an advocate for education and educators, Dr. Bergeson became active in the Washington Education Association for which she was elected vice president in 1981, then president in 1985. As WEA president, she promoted the association's commitment to children and public education and raised citizen awareness of the need and direction for systemic education reform.

Commitment to Transformation: Through their commitment to providing mental health services to students, The Department of Public Instruction has demonstrated its commitment to transformation. Their Safe Schools and Healthy Student Project ensures counseling services to children in numerous districts. In addition, their services created through the bill WA HB 1784 (2003) supports increased coordination of MH and education systems for early screening, diagnosis and treatment of children.

Roles for other TWG Members representing Consumers, Family Members and Agencies

Consumers, family members and organizations will have an instrumental role on the TWG. They will act as the voice of consumers and family members driving the mental health system's reformation. Second, they will foster a recovery-based focus in the TWG's. Finally, they will facilitate and support the Initiative's outreach and education efforts to consumers, family members and the greater community. Each group has noted their specific level of effort and commitment in their letter in Appendix 1. The state agencies listed will here will serve as TWG members with roles equal to their counterparts listed in the prior chart; however they will identify their specific level of effort once the Initiative is underway.

Department/Organization	**Person**
Urban WA: Youth in Action, Seattle;	Youth Representatives Javar Pulliam
Rural WA: Youth Mental Health Advisory Council	Youth Representative: Monique Perry
Western WA: Vancouver, WA;	Adult Consumer Rep: Melanie Green
Eastern WA: Spokane, WA	Adult Consumer Rep: Rita Whigham
Western WA: PAVE;	Family Member Reps PAVE (TBA)
Eastern WA: SAFE WA	Family Member Rep SAFE WA (TBA)
WA Community Mental Health Council	Ann Christian, Policy Analyst
Indian Policy Advisory Council	Liz Mueller, Chair Jamestown S'Klallam Tribe Representative
Common Ground	Lynn Davison, Executive Director
County Community Services	Kasey Kramer, Director Spokane County Community Services Michael Piper, Director Clark County Community Services
Fed. Block Grant Mandated Mental Health Planning and Advisory Council	Joann Freimund, Chair
Washington Association of Sheriffs and Police Chiefs	Don Pierce, Executive Director

TWG Staff to Develop, Implement, Evaluate and Sustain CMHP

Staff supporting the TWG includes an Assistant to the TWG Chair/Project Director, a Project Coordinator, Project Fiscal Planner, Project /Policy Analyst and clerical support. Three Consumer Liaisons will be employed to facilitate outreach and inclusion of consumers and family members. Subcontractual arrangements will be developed with Dr. Chris Cline for consultation on service integration, with Dr. Patricia Bennett for assistance with planning, implementation and sustainability, Dr. Michael Hendryx for training and Dr. Nancy Koroloff and Dr. Joe Morrissey for evaluation.

Section I contains bios and job descriptions for those staff indicated by a * who are not yet hired. Letters of commitment for these individuals are included in Appendix 1. The evaluators' job responsibilities are described in Section F.

Table IV: Staff Supporting the TWG

Name	Expertise	Role	Commit-ment
Cheri Dolezal	Mental Health and Administration	TWG Chair	1 FTE
Ron Jemelka*	Research and Training in Mental Illness	Transformation Project Director/Asst. to TWG Chair	1 FTE
Erin Peterschick*	Legislative policy, Government Relations and Mental Health	Transformation Project Coordinator	1 FTE

TBD	Social Marketing, Promotion and Publications	Communication Specialist	1 FTE
TBD	Business Administration and Human Services	Project Fiscal Planner/Contract Specialist	1 FTE
TBD	Legislative policy, Government Relations and Human Services	Project Planning/Policy Analyst	1 FTE
TBD	Administrative	Clerical Support	1 FTE
TBD	Consumer Advocacy, Mental health	Consumer Affair Liaison Western State Hospital (MHD)	.25 (in-kind)
TBD	Consumer Advocacy, Mental Health	Consumer Affair Liaison, MHD	.25 (in-kind)
TBD	Consumer Advocacy, Mental Health	Consumer Affair Liaison Eastern State Hospital (MHD)	.25 (in-kind)
TBD	Consumer Involvement, Mental Health	Consumer Liaison and Organizer	.25 FTE

TWG Chair, Cheri Dolezal, RN, MBA: Cheri Dolezal will provide the highest level of oversight to the Initiative and serve as its main link to the Governor on a full time basis. Her other duties include: 1) actively involving and supporting all TWG members in the Initiative to facilitate their developing relationships and collaboration; 2) helping the TWG present one unified voice to the public and legislature; 3) addressing and removing any barriers that arise for the TWG or its efforts; 4) ensuring that the Initiative's efforts are continuous and on-going; and 5) building trust and inspiring risk-taking among TWG members and key stakeholders through example and by giving appreciation.

Assistant to the TWG Chair/Transformation Project Director, Ron Jemelka: Ron Jemelka, Ph.D., Senior Research Associate with the Washington Institute for Mental Illness Research and Training at Washington State University, will serve as Project Director of the grant on a full-time basis. In his current position, Dr. Jemelka assists the Washington State Department of Social and Health Services with special projects, including studies of regional mental health needs, co-occurring disorders, and quality oversight of behavioral health programs. As the Assistant to the TWG Chair and Project Director, he will be the primary interface between the TWG and staff supporting the Initiative, giving him supervisory authority over the other staff hired. His duties include giving general support to the TWG Chair, assisting in project oversight, assignment of resources, review of all project documents, and maintaining collaborative relationships with contractors and collaborators.

Project Coordinator, Erin Petershick; Ms. Petershick, M.P.A., will serve as primary support to the Project Director on a full-time basis. In her current position as Project Administrator/MHD Liaison to the Joint Legislative Task Force on Mental Health support staff, she has gained invaluable experience in stakeholder involvement, government processes and an in-depth understanding of the mental health services system at the state level. These assets will serve her well in this position. As Project Coordinator, she will coordinate and attend all project team meetings to ensure that project goals are moving forward and meeting stated outcomes. She will also serve as a liaison to consumer-related stakeholders and contractors, assist with data collection, prepare key communication, monitor activities provided by the grant and assist in follow-up activities.

Communication Specialist, TBD: full-time on the project. Responsible for designing and implementing the social marketing campaigns for the TWG; will work collaboratively with the State Communication Department at the Governor's Office and DSHS to produce materials for the anti-stigma campaign as well as creating other general publicity and outreach related materials.

Project Fiscal Planner/Contract Specialist, TBD: full-time on the project. Will oversee the financial billing, claiming and reporting associated with the project; will create all sub-contracts and manage them in conjunction with the Project Director.

Project Planning/Policy Analyst, TBD: full-time on the project. Will assist the TWG in developing rules, regulations and policy changes as well as work with the legislature to push changes into statue.

Clerical Support, TBD: will be full-time on the project.

Consumer Liaisons: Three Consumer Liaisons will provide 25% to the project, which will be donated in-kind from MHD. They will help shape TWG policy to ensure that it is consumer-driven and recovery focused. They will facilitate the involvement of consumers throughout the Initiative, and develop training and curriculum for TWG and Staff in conjunction with training consultants. Laura Van Tosh is the Director of Consumer Affairs at Western State Hospital. She has 20 years of advocacy and consumer leadership experience, and is founder of the Mental Health Policy Roundtable, a

national education forum. Chris Wilde is the Director of the Office of Consumer Affairs in the Mental Health Division. John Murphy, is an Eastern State Hospital patient ombudsman and member of the Spokane Alliance for the Mentally Ill.

Consumer Liaison and Organizer, TBD: Two FTE consumer positions will work in conjunction with the other Consumer Liaisons, but have a great focus on organizing and developing the consumer network through outreach and technical assistance.

Table V: Contractors

Contractors	Expertise	Role
Christie Cline, MD *, Zialogic	Co-occurring disorders, Systems Change, Integrated services	Planning
Patricia Marrone Bennett, Ph. D.*, Resource Development Associates	Mental Health Systems Redesign, Organizational Development, Intervention, Consumer engagement, Systems Change Planning and Implementation,	Planning, Implementation and Sustaining
Paul D. Peterson, Ph.D., Michael Hendryx Ph.D *, WA Institutes for Mental Illness Research and Training	Children's mental health, co-occurring disorders, Workforce development and Family Psychoeducation, peer support, consumer education	Training
Nancy Koroloff, Ph.D. Regional Research Institute, Portland State University	Children's mental health, Family Support Programs, Consumer Involvement	Evaluation
Joe Morrissey, Ph.D, Ed Norton, Ph.D., Gary Cuddeback, Ph.D, and Marisa Domino, Ph.D., Sheps Center for Health Services Research, University of North Carolina Chapel Hill	Mental Health, Substance Abuse, Criminal Justice	Evaluation
William Waters*, Washington State Clubhouse Coalition	Consumer advocacy and organizing, Mental Health	Implementation Consultant
Mary Ellen Copeland*	Mental Health, Consumer Training	Training
Eric Trupin, Ph.D * and John Dunne*, Division of Public Behavioral Health and Justice Policy, University of Washington	Children's Mental Health, Mental Health	Training
Statewide Action for Family Empowerment	Family Member advocacy, Children's Mental Health	Implementation Consultant
Health in Action	Children's Mental Health, Youth leadership and advocacy, Prevention and Education	Implementation Consultant
2 individuals TBD DSHS/RDA	Public Health, Mental Health and Human Services	Evaluation (Data Infrastructure Development: Researcher 1 and 2)
1 individual TBD, Mental Health Services Division	Mental Health and Management Information Systems	Evaluation (Data Infrastructure Development)

Planning and Integration Consultant, Christie Cline: Dr. Cline will help the TWG plan its efforts, develop the CMHP and determine the best ways to implement service integration. Christie A. Cline, MD, MBA, PC, is President of ZiaLogic. Dr. Cline is a board certified psychiatrist and has served as the Medical Director of the Behavioral Health Services Division of the New Mexico Department of Health. She is largely responsible for the process of strategic planning and implementation of the New Mexico Co-occurring Disorders Services Enhancement Initiative. She also has a Masters in Business Administration with an emphasis in Strategic Planning.

Planning, Implementation and Sustaining Consultant, Patricia Marrone Bennett: Dr. Marrone Bennett will help the TWG with long-term planning and implementation. Prior to joining RDA in 1995, Dr. Marrone-Bennett spent 25 years working in the non-profit sector as an executive director. As the executive director of multi-service organizations providing prevention and intervention mental health services to low income children, youth and their families, she has worked with service providers, consumers and their families and funding agencies. She has also addressed policy issues at the State level on mental health and advocated for the rights of consumers and their families. She is the primary author of numerous plans and reports. Dr. Bennett is also a family member of several severely mentally ill individuals and has extensive personal experience in advocating for her loved

ones within public mental health systems. She earned her Ph.D. in Human and Organizational Development from the Fielding Graduate University.

Training Consultant, Michael Hendryx: Dr. Hendryx and the WIMIRT team will assist the TWG in training for members, consumers and other key stakeholders. Michael Hendryx, Ph.D., is director of the WIMIRT Eastern Branch, at Washington State University Spokane, serving as director since 2003. The Institute's work focuses on performance measurement, evidence-based care and treatment for co-occurring mental illness and substance abuse.

Evaluation Consultant, Nancy Koroloff: Dr. Koroloff will be Principal Investigator for the evaluation, focusing on the consumer involvement component of the project. Nancy Koroloff is a Professor in the Graduate School of Social Work at Portland State University and Director of the Regional Research Institute for Human Services (RRI). The aim of RRI is to improve human services through applied social research. During Dr. Koroloff's tenure at RRI, it has become one of the nation's major research institutions on Children's Mental Health and Family Support Programs.

Evaluation Consultants, Joe Morrissey, Ed Norton, Marissa Domino, Gary Cuddeback: This group of University of North Carolina – Chapel Hill evaluation consultants, directed by Dr. Joe Morrissey, will focus on collaborating with local leaders in the design and implementation of Washington State system evaluations, conducting multi-agency system performance assessments, and assessing consumer and family outcomes. Currently, Dr. Morrissey is PI for two studies funded by the National Institute of Mental Health, one in King County, Washington focused on cost shifting between mental health services and jails under Medicaid capitation and the other in North Carolina focused on services utilized by families with an autistic child. He has been a principal collaborator in national evaluations of many SAMHSA service demonstration programs for homeless mentally ill persons, managed care for persons with severe mental illness, jail diversion for persons with co-occurring mental health and substance abuse disorders, and women with co-occurring disorders and trauma.

Implementation Consultant, William Waters: Executive Director of Rose House, an International Center for Clubhouse Development (ICCD) certified clubhouse program, Mr. Waters has developed and directed three other successful clubhouse programs in Washington State. He is the current President of the Washington State Clubhouse Coalition (WSCC), past Chair of the Education and Employment Committee, past member of the Advisory Board to the International Center for Clubhouse Development, and past member of the Faculty for Clubhouse Development. He has over 20 years experience in the development and operation of psychiatric and vocational rehabilitation programs serving persons with mental illness. Mr. Waters will assist the TWG in ensuring that consumers are fairly represented in the TWG committees by conducting outreach and providing support. In addition, he will facilitate on-going consumer focus groups on issues important to the Transformation.

Training Consultant, Mary Ellen Copeland: Ms. Copeland, President of the Copeland Center for Wellness and Recovery will provide training to TWG members, consumers and stakeholders on the recovery model and the WRAP approach. Ms. Copeland is an author, educator and mental health recovery advocate. Her work is based on her on-going study of coping strategies of people experiencing psychiatric symptoms, and how people have gotten well and stayed well. She undertook these studies out of her own frustration with dealing with her own recurring symptoms. She has achieved long term wellness by using many of the coping strategies she learned while writing her books.

Training Consultants, Eric Trupin, Paul Peterson, John Dunne: As Michael Hendryx's University of Washington WIMIRT cohorts, Eric Trupin, Paul Peterson, and John Dunne will provide training to TWG members, consumers and other key stakeholders. Dr. Eric Trupin is Professor and Vice Chair in the Department of Psychiatry & Behavioral Sciences of the University of Washington School of Medicine in Seattle, and Director of the Division of Public Behavioral Health and Justice Policy.. In 1989, in collaboration with the Washington Legislature and Governor, he established the Washington Institute for Mental Illness Research and Training. Drs. Dunne and Peterson are esteemed faculty of WIMIRT, and recognized nationally as a unique public/academic collaboration

Implementation Consultant, SAFE WA: SAFE WA will provide training and support to families for grant activities to ensure their continued involvement. SAFE WA is a network of family organizations focused on supporting parents and caregivers raising children with emotional, behavioral, or mental disorders. SAFE WA assists organizations in sustaining, strengthening and expanding their local networks. SAFE WA fosters partnerships with child-serving systems to increase the common

voice of parents and caregivers in child-serving systems and provides various types of trainings. Individual organizations belonging to SAFE WA provide support, information, and training to families.

Implementation Consultant, Health N'Action: Health N'Action will provide training and support to youth consumers to foster their active participation in the Initiative. Health N'Action is an organization of young people, ages 13 to 22, who are concerned about their right to live a full and healthy life. They provide prevention and education services to the community around the issues of mental health, chemical dependency, tobacco use, teen pregnancy, homelessness, HIV/AIDS, suicide, gun violence in our schools, and health care availability.

Evaluation/Data Infrastructure Consultants from DSHS/RDA, TBD: These consultants will enhance and broaden the existing management information systems for TWG activities and reforms.

Evaluation/Data Infrastructure Consultant from DSHS, TBD: This consultant will work in conjunction with the consultants from RDA to improve the MIS systems for TWG activities.

Timeline for First Year Activities

TASK AREA	BEGIN (Project Month)	END (Project Month)	PRIMARY RESPONSIBILITY
Provide orientation to TWG Chairperson	*1*	*1*	*Project Director*
Finalize planning process	*1*	*2*	*Proj. Dir./Prog. Coord.*
Identify, bring on Planning Consultant	*1*	*2*	*Proj. Dir./Prog. Coord*
Identify, bring on Training Consultant	*1*	*2*	*Proj. Dir./Prog. Coord*
Hire Other Project Staff	*1*	*3*	*Proj. Dir./Prog. Coord.*
Convene Transformation Work Group	*2*	*Ongoing*	*Chairperson*
Determine training needs of TWG members and develop plan	*2*	*2*	*Proj. Dir./Training Consultant*
Train TWG members	*2*	*Ongoing*	*Training Consultant*
Establish subcontracts	*2*	*3*	*Project Director*
Establish TWG subcommittees	*3*	*3*	*Project Director*
Determine training needs of statewide consumer/family member groups and develop plan and curriculum	*3*	*3*	*Proj. Dir./Training Consultant*
Develop social marketing/education strategy	*3*	*4*	*Proj. Dir./Prog. Coord.*
Review and refine Vision Statement	*4*	*4*	*TWG*
Implement outreach strategy	*4*	*5*	*TWG/Project Staff*
Provide training to consumer/family member groups	*4*	*Ongoing*	*Training Consultant*
Finalize evaluation plan	*5*	*6*	*Evaluator/Proj. Dir.*
Provide technical assistance and advocacy to promote collaboration between local MH systems and the State	*5*	*7*	*Planning Consultant*
Modify the Client Services Data Base	*5*	*8*	*Evaluator/RDA*
Conduct and finalize Needs Assessment/Resource Inventory	*5*	*9*	*Planning Consultant*
Conduct county-level public forums	*5*	*10*	*Planning Consultant*
Identify training needs of senior staff in state departments and other state workers, develop plan and explore curriculum	*6*	*8*	*Proj/Dir./Planning Consultant*
Set up database, and data collection and monitoring systems	*6*	*8*	*Evaluator*
Recruit consumers/family members for evaluation team	*6*	*9*	*Evaluation Committee*
Train Project Staff in collection of GPRA data	*7*	*8*	*Evaluator*
Establish mentor program for consumer/family member evaluators	*7*	*9*	*Evaluation Committee*
Enter GPRA data	*7*	*Ongoing*	*Evaluator*
Develop multi-system performance monitoring system	*8*	*10*	*Evaluator*
Produce monthly and quarterly evaluation reports for internal use	*8*	*Ongoing*	*Evaluator*
Regular reporting to TWG	*Ongoing*	*Ongoing*	*Project Dir./Proj. Coord.*
Regular review of project activities; action recommendations to TWG	*Ongoing*	*Ongoing*	*TWG*
Draft of Comprehensive Mental Health Plan	*8*	*10*	*Planning Consultant*
Solicit public comment on CMHP	*10*	*11*	*Planning Consultant*
Finalize CMHP and submit to SAMHSA/CMHS for approval	*11*	*12*	*Planning Consultant*

TASK AREA	BEGIN (Project Month)	END (Project Month)	PRIMARY RESPONSIBILITY
Report data to the national evaluator as required	*Ongoing*	*Ongoing*	*Evaluator*

Section F: Evaluation and Data

Overview

The primary purpose of Partnerships for Recovery's evaluation is to provide information useful to managing the Transformation and to hold those involved accountable to the outcomes specified in this proposal. Secondly, the evaluation has been designed to ensure accountability to SAMHSA for performance and outcomes of the Initiative. The plan rests upon two fundamental principles:

- ***The evaluation process will be consumer and family driven***. Consistent with the President's New Freedom Commission on Mental Health, the evaluation plan for system transformation in Washington State ensures that both adult and youth consumers and their families play active roles. Through establishing a Consumer Evaluation Subcommittee and a Family Member Evaluation Subcommittee and through representation on all committees and workgroups, the input of consumers and family members will drive all facets of the evaluation process.
- ***The evaluation process will be culturally sensitive***. Washington State is committed to conducting its evaluation of system transformation in a culturally sensitive way that recognizes, incorporates, practices, and values cultural diversity in policies and practices. Consequently, we will rely upon input from Washington State's rich diversity of racial and ethnic minority groups in all facets of the evaluation.

A transformed mental health system centers on development of an infrastructure that allows consumers, family members and other stakeholders to monitor progress, evaluate outcomes, and assess the need for mid-course corrections. Implementing and sustaining large-scale changes in the way state and county agencies do business requires a multi-agency database and a capacity to use data to inform multiple stakeholders and guide implementation.

The evaluation will have three principal components:

1. Development and Implementation of GPRA measures;
2. Collection and reporting of SAMHSA's National Outcome Measures;
3. Implementation of a Theory of Change evaluation to assess the overall impact of the Initiative on achieving the six goals of the President's New Freedom Commission.

Leadership of the external evaluation will be shared by the Regional Research Institute for Human Services of Portland State University and the Cecil G. Sheps Center for Health Services at the University of North Carolina, supported internally by the DSHS Research and Data Analysis Division.

Consumer, Family, and Youth Involvement in the Evaluation

The evaluation process for the transformation effort provides one of the avenues for investing consumers, youth and family members with decision-making powers over transformation activities and outcomes. This will be accomplished through several mechanisms. First, the TWG will establish two evaluation subcommittees, one for Families and Youth and one for Adult/Older Adult consumers. These committees will review all proposed evaluation activities and findings to determine if they are responsive to consumer- and family member-identified concerns and address cultural issues. The subcommittees will advise the TWG regarding the form and substance of the evaluation designs and about the interpretation of results. Membership of the two subcommittees will come from individuals nominated by statewide and local consumer and family member groups and by providers. Each subcommittee will be co-chaired by a TWG member representing consumer, family or youth groups.

Second, the TWG will develop a Family and Consumer Evaluation Team (FACET) that will be integral to all evaluation efforts. They will participate fully in determining the responsiveness of the Transformation to consumer voice and concerns, recovery, and cultural sensitivity. Under the direction of Dr. Nancy Koroloff from Portland State University, a national leader in promoting family voice and recovery, the two evaluation subcommittees will be key to recruiting, interviewing and selecting two co-investigators who will be hired to constitute the core of FACET. They will work closely with Dr. Koroloff to plan and implement a strategy for identifying and coordinating the ef-

forts of those individuals from the family member or consumer communities who have an interest in being involved in the evaluation of the Transformation. FACET will also work closely and provide support to the two evaluation subcommittees, and will attend all evaluation meetings.

Third, Partnerships for Recovery will support a series of training events intended to increase the skills and knowledge of consumers and family members regarding the evaluation. During the first year of the grant, two day trainings will be held in several parts of the state, followed by a second training course which teaches family members how to participate on an evaluation team. Providing this training to members of the two sub committees and to other interested consumers and family members across the state will result in an informed and powerful consumer and family member voice that can influence the transformation. The two co-investigators will also be able to help local and statewide groups build skills and identify members to become involved with the evaluation of the Transformation and with smaller evaluation efforts within the local communities.

Finally, the TWG will establish a small group of University consultants who are family and consumer friendly and interested in working with advocacy groups. In addition to Dr. Koroloff from PSU, two faculty will be identified from the University of Washington and one from Washington State University. In this way all regions of the state will have access to research and evaluation supports. A group of potential applicants will be identified and interviewed by the Consumer Evaluation Committee and the Family member Evaluation Committee who will make the selection. These faculty will consult with the two subcommittees and be available to advise local and statewide consumer and family member groups. Each faculty chosen will be given money to support a graduate student to expand the consultation and staff support available.

The two subcommittees and the statewide and local advocacy groups will be encouraged to identify evaluation studies that are germane to the concerns of consumers and families and may not be addressed by the main evaluation design. Mini contracts will be made available to family and consumer organizations to conduct small evaluation studies on these topics. The mini-grants of up to $10,000; are expected in each year of the grant. The Family and the Consumer Evaluation Sub Committees will decide who will receive these grants and will be.asked to work together for this purpose.

Together with Partnerships for Recovery staff and other consultants, our goal will be to create multiple roles for consumers and family members in evaluation, to establish roles with significant decision making authority, to actively employ these individuals in the enterprise and to create learning paths and career development opportunities for those interested in this work. This approach to the role of consumers and family members in evaluation represents a significant departure for this State, and demonstrates a clear commitment to consumer and family member voice in the Transformation.

Existing Resources and Approaches to Data Collection

Consistent with the President's New Freedom Commission Report, Washington State has long recognized that persons with serious mental illnesses or serious emotional disturbances may have contact with a broad range of non-mental health settings (e.g., adult or juvenile justice, education, child welfare, vocational rehabilitation, Medicaid). In response to this recognition, and prior to the SAMHSA State Transformation RFA, administrators and policy makers in Washington State recognized the importance of improving screening and referral processes and coordinating services provided across DSHS. To this end, the state established a centralized Research and Data Analysis (RDA) division within DSHS which has access to and coordinates data from across multiple Divisions. RDA has constructed a central research database which matches client service records from sixteen different data sources that record child and adult service, authorization, and management information. This technology allows RDA to record the DSHS services used by children and adults who are mental health consumers over time, the cost of those services, contact information, and consumer demography. This central research data warehouse, known as the Client Services Data Base, or CSDB, is then used to provide data for service integration initiatives across the department. The development of the CSDB is critical to creating the foundation for present and future system transformation. With additional enhancements, it will play a critical role in continuous quality improvement feedback and provide information to support the management of transformation

Information and Data Infrastructure Enhancements needed to enable Transformation.

Partnerships for Recovery will implement an array of enhancements to Washington's information infrastructure that are designed simultaneously to support the evaluation, guide the Transformation

process, and provider information and accountability to consumers and policy makers. Elements of this Infrastructure will include:

- Expansion of the RDA Research database to include an outcome measures, targeted to provide reporting on the SAMHSA National Outcome Measures and on elements of the GPRA related to direct consumer outcomes.
- Expansion of the consumer satisfaction survey to include a greater range of outcome measures and to survey mental health consumers who are served by non-MHD systems.
- Implementation of a random digit dial telephone survey to track population and consumer trends in attitudes toward mental illness, stigma, help-seeking behaviors, and population-level outcomes. This will be used a method for tracking and reshaping the Initiatives social marketing activities.
- Development of a web-based HIPAA-compliant client chart.
- Develop of an ongoing, annually updated resources inventory.

Transformation Evaluation Activities

Partnerships for Recovery will expand current data and evaluation capabilities to address GPRA indicators as well as SAMHSA's National Outcome Measures (NOMS) to assess overall system performance. The GPRA indicators will be collected, managed, analyzed, interpreted, and reported to monitor, guide and evaluate the process of the evolving transformation., The collection, management, analysis, and interpretation of the NOMS will assess the impacts of the evolving transformation (i.e., who, what, when, where, and how) on individual consumers and their families. These activities are described below.

Development and Reporting of Government Performance and Results Act (GPRA) Measures

The following steps will be taken to ensure Washington State's ability to collect and report on the GPRA measures:

Step 1: A GPRA workgroup will be appointed by the Transformation Work Group. Membership will include representatives of affected state, county and local agencies, representatives of the Consumer Evaluation subcommittee and the family and youth evaluation subcommittee, as well as other stakeholders represented on the TWG.

Step 2. With MHD, RDA, and MHT staff leadership, the GPRA Workgroup will develop a comprehensive plan to measure and report required GPRA measures and to propose GPRA measures unique to the state of Washington.

Step 3. The GPRA Workgroup will submit the recommended GPRA measures, annual performance targets, and budget implications, if any, to the two evaluation subcommittees for review/revision/approval. These two committees will then make a recommendation to the TWG.

Step 4. The TWG will finalize the GPRA measures and approve procedures to collect and report on the measures. These will then be submitted to the SAMHSA Project Officer for review/approval.

Step 5. GPRA and related performance measures will be reviewed by the two evaluation sub committees and at regular TWG meetings before reporting to SAMHSA. They will be modified, if needed, by the TWG using the process described in the steps above, in coordination with SAMHSA Project Officer and the coordinators of SAMHSA's national field evaluation.

These steps will allow the Partnerships for Recovery to monitor the process of the transformation using GPRA outcomes for all six of the goals of a transformed mental health system as outlined by the President's New Freedom Commission on Mental Health. GPRA outcomes will be collected and reported as required by SAMHSA.

National Outcome Measures (NOMS)

The evaluation of the NOMS will examine the impacts of the transformation on public health and public safety outcomes for consumers and their families.

The micro-level evaluation of the NOMs will address the who, what, when, where, and how of the transformation's impacts on both child and adult consumers and their families. The following issues, among others, will be addressed in this ongoing phase of the evaluation:

1. *The need for mental health care*. How many people have been screened or served somewhere in DSHS in ways that indicate a "need" for mental health services? What is their age, gender, race, ethnicity and location?

2. *Mental health service use and costs across systems*. How many consumers needing treatment

used mental health services from DSHS? How many from MHD, how many from other parts of the agency? Were the rates and patterns of mental health service use different for different subgroups of people? What kinds of mental health services were used, and what did they cost? How many consumers needing treatment accessed services through non-mental health settings? How well were their needs and preferences met?

3. *Mental health service cost offsets*. How do non-mental health costs across DSHS compare for those who received various sorts of mental health services, including "no treatment." Are there state costs to NOT serving people, which could be used to expand treatment?

4. *Mental health service outcomes for consumers and families*. How did various groups of people needing and/or receiving mental health treatment fare in their daily life? How do the groups compare in employment and wages, school enrollments and success, arrests and convictions, and use of medical care? How do consumers and family members feel about the way they were served? Did they report being involved in individualized planning for their services and supports?

Sound quasi-experimental designs, econometric analyses, multi-level modeling and structural equations will be used to answer critical questions about the macroloevel impacts of mental health transformation. The questions include but are not limited to:

- How do the mental health outcomes for child and adult consumers compare before, during, and after the transformation?
- How do community outcomes for mentally ill persons detained in jail (e.g., public health and public safety) compare before, during, and after the transformation?
- What are the intersystem effects of the transformation with respect to point-of-service entry (i.e., irrespective of entry point, do consumers get appropriate services?), information sharing and accountability among agencies involved in serving multiple system users, and the alignment of policies and procedures across multiple systems (i.e., criminal justice and Medicaid)?
- What are the costs of these various transformation efforts? Are cost-efficiencies realized from expanded service delivery and in what sectors?
- What regional differences are observed, and how do these relate to regional demographic characteristics, service configurations, funding arrangements, and other ecological factors.

Theory of Change Evaluation

A theory of change model is provided in Section A, above. It is, however, lacking the "inputs" and "activities" columns normal in these models. This is because these elements remain to be specified through the planning process outlined for the first planning year. The evaluation team will conduct a formative evaluation during the first project year to assist the Initiative to develop a complete logic model, with activities, timelines, and benchmarks clearly specified. Then in Years 2-5 the evaluation team will conduct an impact evaluation using a theory of change evaluation approach. In this evaluation, long-term outcomes that will be assessed will be operationalizations of the six President's New Freedom goals, and intermediate outcomes will include outcomes mandated by GPRA.

The changes in the system of care will be evaluated using GPRA and other measures to construct indices of fidelity and consumer involvement as follows:

1. *Transformation Fidelity Index Statewide*. This index will address such questions as: How has governance changed? Is there more collaboration? How has policy development changed?
2. *Transformation Fidelity Index Local*. This index will address such questions as: Have local RSNs adopted evidence-based practices? Individualized care plans? Collaborated more with other parts of the community serving consumers with mental health problems?
3. *Consumer Infrastructure Index:* This index will include items addressing the organization, funding, number of local branches and members, and consumer involvement in state and local policy-setting bodies.

Feedback and Continuous Improvement

The evaluation team will work with FACET, the two evaluation subcommittees, and the TWG to report, evaluate, and synthesize evaluation findings on an ongoing basis throughout the transformation process and beyond. These findings will be disseminated in series of reports, presentations, and web mediums among consumers, family members, advocacy groups, key stakeholders, administrators, and other constituents in order to facilitate dialogue about the transformation's processes and impacts. This dialogue will be used to re-shape, re-focus, and modify the transformation.

Evaluation Team

The evaluation team that will implement the Partnerships in Recovery evaluation plan consists of members of the Family and Consumer Evaluation Team, staff from the DSHS Division of Research and Data Analysis, the Mental Health Division Research Group, and two university-based research groups from Portland State University and the University of North Carolina, as described below.

Regional Research Institute for Human Services, Portland State University.

The Regional Research Institute for Human Services (RRI), a part of the Graduate School of Social Work, has been conducting research and evaluation to improve social services and service delivery systems since 1972. The Research and Training Center on Family Support and Children's Mental Health sits within the RRI and is the only RTC in the nation to focus on expanding family voice and advocacy in the mental health service delivery system. In this vein, the RTC has developed measures of family participation in services, service coordination from the family perspective and has helped to develop the Federation Curriculum, "The World of Evaluation, How to Make it Yours". Recently, RTC staff conducted a study to determine what information and skills researchers need in order to work effectively with family members on the evaluation team. A web-based curriculum based on this study is under development. In addition to the RTC, researchers within the RRI have provided evaluation support to three CMHI Systems of Care and a Partnership for Youth Transition Grant. RRI researchers are leading experts in involving family members in the evaluation process and are developing approaches to helping youth participate as youth evaluators.

In addition to its prominence in children's mental health research, RRI has conducted a number of studies on adult mental health services, consumer run services, substance abuse services and juvenile and criminal justice programs. In all of its projects, consumers of services are included in multiple roles, from employment as research assistants or data collectors to serving on advisory panels for evaluation. The RRI houses Peer Expertise Network, one of five grants in the nation to test the effectiveness of peer operated services.

UNC group

The Cecil G. Sheps Center for Health Services at the University of North Carolina research is the largest university-based center for studies of health services delivery in the nation. Its 200-member faculty and staff conduct policy and programmatic studies at the national, state, and local levels. The group that will participate in this evaluation is headed up by Joseph P. Morrissey, Ph.D, Professor of Health Policy and Psychiatry in the Schools of Medicine and Public Health. Other members of the UNC-CH Research team include Edward Norton, PhD, Marisa Domino, PhD, Gary Cuddeback, PhD, and Chunyuan Liu, MS. For the past decade, the UNC team has been engaged in multi-system studies of service delivery in King County (Seattle), WA. This work started with the SAMHSA-funded (1993-00) evaluation of the ACCESS Demonstration for persons homeless and mentally ill, continued with pilot studies of jail use under managed care funded by the MacArthur Foundation (2000-01), and continues currently with a longitudinal study of multi-system service use under managed care supported by a research grant from the National Institute of Mental Health. As part of these efforts, evaluation studies have been undertaken on the inter-organizational structure of service system integration in two areas of Seattle, cost shifts from county mental health to the jail under a Medicaid behavioral health carve-out, and changes in the likelihood of jail use by a variety of mentally ill subgroups following the adoption of managed care. Much of the macro-level evaluation of system transformation will build upon these efforts.

DSHS and MHD Research Groups

The Research and Data Analysis (RDA) Division of DSHS (Dr. Elizabeth Kohlenberg, Director) mission is to provide analytical information and answer customer questions regarding risk, need, demand, use, supply, cost and outcomes of DSHS human services. A unique specialization is the analysis of clients who use services from multiple DSHS programs. Agency managers, the Governor's Office, Legislature, other local, state and federal agencies, and the general public all use this information. RDA also houses the Human Research Review Board, which protects the privacy and confidentiality of clients and members of the general public who are subjects in research projects.

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Section I: Biographical Sketches and Job Descriptions

Section J: Confidentiality and SAMHSA Participant Protection/Human Subjects

Protect Clients and Staff from Potential Risks

Since this Initiative is purely a systems change and organizational enhancement project, there will be no clients receiving direct services as a result of the transformation process. Although not the direct target of the infrastructure development activities, consumers and their families will be the ultimate beneficiaries of the system improvements. While no potential risks of participating in the infrastructure enhancement activities have been identified for participants strict adherence to Health Insurance Portability and Accountability Act (HIPAA) procedures will guard against risk to confidentiality. Participants will not be asked to reveal information regarding their diagnoses, their past or current treatment in any evaluation or infrastructure building activities. There are two categories of participants for who protections will be relevant:

Staff completing surveys or participating on subcommittees or work groups. Risks to this class of participants include the risk that they may express opinions that have or are perceived to have negative repercussions for the institution that employs them, and that they are therefore punished as a result. The results of all surveys, key informant interviews, and other evaluation information collection processes will be anonymous, and no individual transcripts will be released—only statewide summaries.

Consumers, family members and youth completing surveys, receiving evaluation training, and participating in subcommittees or work groups. Although these individuals will not be participating as clients, they may well be clients of the service systems that are the objects of this initiative. Protections will be in place so that information or opinions that they give in the process of participating in this project may adversely impact the course of treatment of them or their families. The results of all surveys, key informant interviews, and other evaluation information collection processes will be anonymous, and no individual transcripts will be released—only statewide summaries. Consumers who are participating in public forums will receive a summary of their rights and protections and be given telephone numbers of individuals they may contact if they feel that their rights are being violated in any way.

Should we determine that human subjects would be involved in any evaluation activities in future years of the grant, we will submit a detailed plan for approval by the DSHS Human Research Review Board (HRRB) to ensure protection of consumers. The DSHS research review process is stipulated in Chapter 388-10 WAC and 45 CFR 46, which protects rights and welfare of research subjects. The Department's assurance identification number is M-1076. Any future research would also be reviewed by the IRB's at Portland State University and University of North Carolina.

Fair Selection of Participants

This Initiative will not be providing any direct service to, or evaluation of mental health consumers. The target of this initiative are the institutions who serve that target population. However, consumers, family members, and advocates will be selected to complete satisfaction surveys, serve on work groups and committees, and participate fully in all phases of the evaluation. Partnerships for Recovery will support a series of training events intended to increase the skills and knowledge of consumers and family members regarding the evaluation process and being involved in evaluation. Membership on the Families and Youth and Adult/Older Adult evaluation subcommittees will come from individuals nominated by statewide and local consumer and family member groups and by providers. These two subcommittees will be key to recruiting, interviewing and selecting two co-investigators who will be hired to constitute the core of Family and Consumer Evaluation Team (FACET). Careful selection of participants will be observed to ensure representation from the various racial/ethnic backgrounds of the population as well as regional and age division representation. Similarly, the selection of training staff will consider cultural diversity as an important factor.

Absence of Coercion

The subject institutions will be required to participate, however there are no individual clients for this Initiative. Institutions will be required to fulfill participation commitment as part of the contractual responsibilities of their funding sources participating on the TWG.

Volunteers—family members and consumers—will be recruited to participate on a purely voluntary basis in trainings, advisory bodies, and in advocacy roles. Entry into the infrastructure grant activities will be completely voluntary. Participants will be notified that participation is completely voluntary and that non-participation will not affect the services currently provided or services they will receive in the future. Additionally, individuals will be informed that they can withdraw at anytime during the project implementation without repercussion.

Participant compensation: There will be compensation for expenses and travel costs for consumer-participants on the committees, workgroups, and evaluation trainings.

Data Collection

Client Satisfaction and Feedback on Mental Health Services and Transformation Efforts. MHD will expand its survey capacity over the course of this transformation. Beginning in Year 1, survey capacity will be expanded to include mental health consumers, both inside and outside of the traditional mental health system. Transformation funds will be used to collect outcome data for consumers served in non-mental health settings, particularly for the aged and disabled, children and youth, and working-age non-disabled people. The MHSIP survey currently used will be expanded to address a larger set of perceptions and concerns. These will include perceptions of changing attitudes around stigma, availability of services related to mental health of consumers, such as safe and secure housing, transportation, employment assistance, day care, etc. Specific content will be determined by the consumer evaluation subcommittee, and the family and youth evaluation subcommittee of the TWG. These statewide surveys conducted by the Washington Institute for Mental Illness Research and Training (WIMIRT) for the Mental Health Division. A copy of the child and adult surveys are attached in Appendix 2.

Privacy and Confidentiality

Confidential data storage and access are critical issues for this proposal. Confidentiality and security are addressed in the MHD Security User Guide. Materials in the current manual are: personnel security, physical security, access security, data processing functions, electronic message systems, computer viruses, data sharing agreements, investigation of suspected data processing crimes, security reviews and inspections. The Division's confidentiality and security procedures have been audited by the State Auditor. A self-audit of LAN security, with oversight from DSHS Office of Accounting Services, was recently completed satisfactorily. Each grant staff will have a signed Oath of Confidentiality on file in the MHD.

Data from the statewide survey will be collected through a custom written web-based interviewing application. Phone interviewing will be conducted using WIMIRT CATI (Computer-assisted Telephone Interviewing). Although all contact with the interviewee is provided by a human interviewer, the CATI system dials the call, provides conditional interviewer prompts and scripts, and allows the answers to be directly recorded into the database. All interviewers are thoroughly trained in participant confidentiality requirements and sign an Oath of Confidentiality.

When consumer identified information is shared between divisions, a data sharing agreement is prepared and signed by the division directors involved in the data exchange. The data sharing agreement includes the scope and purpose for the agreement, a description of the data to be shared, the period of the agreement, justification for access, the method of transfer including mechanisms to protect the data during transfer, processes to ensure confidentiality, and a description of disposition of the data once the project is completed. Any staff member having access to the consumer-identified information must sign an Oath of Confidentiality. MHD currently has data sharing agreements with the Medical Assistance Administration for exchange of hospital billing data and for shar-

ing information on SSI/Healthy Options participants, with the Research and Data Analysis for the CSDB and for the Employment Security Outcome database. All data are encrypted and submitted on secured intranet servers. Access to databases is password protected as is entry into the MUD intranet site. Any staff having access to the intranet site must sign an Oath of Confidentiality.

Adequate Consent Procedures

Although formal informed consent to participate in infrastructure development activities will not be required, participants will be notified that they will be asked to complete satisfaction surveys and interviews. Informed (written or oral) consent will be obtained from all participants who are interviewed or observed. Where participants are unable to grant informed consent, such consent will be sought from parents or guardians. Participation in treatment activities that are the ultimate result of infrastructure development will follow treatment consent policies of each institution.

Risk/Benefit Discussion

This project has a great potential to benefit the target population and their families by increasing access to mental health care as well as improving the quality of service, and helping to promote a family orientation, and increasing cultural competence. On the risk side, no individuals will be at risk as a result of receiving services, since no direct services will be provided through this project. There is a minimal risk to people who are clients or family members of clients who choose to voluntarily speak out in the public arenas provided by this initiative for planning and training. All possible efforts will be made to inform participants of this risk, and of their rights and recourse in the event that they are discriminated against due to their public opinions in these forums.

APPENDICES

Appendix 1: Letters of Commitment and Memoranda of Understanding

Memorandum of Understanding Signatories:

Tim Brown
Ken Stark
Michael O'Brien
Cheryl Stephani
Robin Cummings
Doug Porter
Kathy Leitch
Harold Clarke
Karen Lee
Terry Bergeson

Letters Of Commitment

Mary Selecky
Monique Perry
Javar Pulliam
Rita Whigham
Joanne Butts
Ron McCoy
Donna Roberts
Michael Fitzpatrick
Michael Faenza
Bill Vogler
Ann Christian
Judge Michael Trickey
Don Pierce
Lynn Davison
Tina Orwall Shamseldin
Kasey Kramer
Michael Piper
Joann Freimund
Laura Van Tosh
John Murphy
Chris Wilde
Gates Foundation
Chris Cline
Pat Bennett
Nancy Koroloff
Joe Morrissey
Elizabeth Kohlenberg
Eric Trupin
Paul Peterson
Michael Hendryx